

MEDICARE FRAUD, WASTE, AND ABUSE

HEARING BEFORE A SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS UNITED STATES SENATE ONE HUNDRED SIXTH CONGRESS

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MEDICARE FRAUD, WASTE, AND ABUSE

THURSDAY, MARCH 9, 2000

U.S. SENATE,
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN
SERVICES, AND EDUCATION, AND RELATED AGENCIES,
COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 9:30 a.m., in room 216, Hart Senate Office Building, Hon. Arlen Specter (chairman) presiding.

Present: Senators Specter, Craig, and Harkin

OPENING STATEMENT OF SENATOR ARLEN SPECTER

Senator SPECTER. Ladies and gentlemen, the Appropriations Subcommittee on Labor, Health, Human Services, and Education will now proceed.

Today, we will have a hearing on the annual audit of the Medicare Program, where we continue to show enormous losses. We have a distinguished panel this morning. And we will proceed very promptly.

We have on the floor confirmation hearings on two Ninth Circuit judges. And it is my intention to move this hearing right along and to conclude it in less than an hour. I am going to have to excuse myself shortly before 10:30, in any event.

This is a very important hearing. As we focus on the losses to Medicare, which is a program of enormous importance, needs every last dollar it can muster, very important considerations on prescription drugs pending, very important considerations on Medicare reform.

The President's Commission has worked on this matter. There is a lot of attention in the Congress, and to have billions of dollars in losses is totally unacceptable.

The first Medicare audit was conducted in 1997 and found that approximately \$23 billion or 13 percent of Medicare payments should not have been made. In 1998, that number was reduced significantly, at least according to the audit, to \$12.6 billion, or 7.1 percent.

And the audit in 1999, which we will hear about in some detail, is—shows a loss of \$13.5 billion, with the mis-payments, an error rate of 7.97 percent.

This may not be significantly significant in terms of decrease, according to the Inspector General's report, but it is highly significant when you talk about \$13.5 billion being lost. The critical issue is how to stop these losses.

And one of the issues that I am going to want our distinguished witnesses to address today is the issue of a pattern of conduct on individuals who are making these erroneous billings and collecting this money. If it is fraud, it may be insufficient to act simply to collect the money or to settle the civil cases.

If it is criminal fraud and if there is a repetitive pattern, then serious consideration ought to be given to criminal prosecutions. There is nothing like a criminal prosecution in the white-collar area to get results.

It is one thing to reimburse the Government, to pay damages, coming out of the corporate treasury, not too painful. Going to jail is very, very painful. And white-collar crime sometimes requires that kind of action.

Criminal fraud has a higher standard of proof than civil fraud. But where certain individuals or companies are responsible on a pattern of conduct over a period of time, and the intent can be shown, we are going to be exploring the issue as to whether some of the criminal prosecutions might not be the appropriate—appropriate therapy.

I may have a little predisposition to that from my own background as a prosecuting attorney, but I have seen how prosecutions of white-collar crime can be highly, highly effective. Jail compared to dollars is a very, very different deterrent.

Well, I have attempted to filibuster here until my distinguished colleague arrived.

Actually, I had planned to limit my opening statement to 4½ minutes. And I am now up to 4½ minutes.

Senator HARKIN. Well, I like what I have been hearing so far.

Senator SPECTER. I yield to my partner in this matter.

I would like to say that when the Democrats controlled the Senate, he was chairman and I was ranking. I like this arrangement better.

But it is pretty close to a 50/50 partnership no matter which party controls the Senate, which I think is the way that we ought to be conducting our business generally, but especially on this subcommittee.

Senator Harkin.

OPENING STATEMENT OF SENATOR TOM HARKIN

Senator HARKIN. I appreciate that, Mr. Chairman. You are absolutely right. It has been a great working relationship. I appreciate your leadership and your—your working relationship with—with me and with our side of the aisle over here. It has just been a—it has been a great team effort. I really appreciate it, and especially on this issue.

I just really want to commend you for—for really pressing ahead on this issue. I remember the first hearing we had on this that I remember—that I had on it was 1990. That has been 10 years ago, on this issue when we first started having hearings on this subcommittee and we continued it, and then the Chairman has continued it when—when his party took over the Senate.

So, again, I thank you for—continuing this, because, you know, taxpayers and the people I have talked to out there just cannot understand how we could have had \$23 billion in waste and

abuse in Medicare in—in a given year, and how could that possibly happen?

And I think for too long all of us—and I am not pointing fingers—but I think all of us here, we, you, just sort of just kind of let it go and never really paid much attention to it.

But we have in the past few years identified and stopped abuses that would have cost taxpayers billions of dollars, and I personally want to thank Ms. DeParle for her great leadership in this area and taking this on.

And I also want to thank June Gibbs Brown, our—our really tough and really good Inspector General who has really done a great job in ferreting this out and getting the information in that we needed and that Medicare needed, that HCFA needed, to start cutting back on this tremendous outflow of money and waste and abuse and fraud.

Well, today's hearing provides an important opportunity to take stock of where we are and where we ought to be going in our efforts.

Today, the findings of the 1999 Independent Audit is being released and I have to say there is good news and there is bad news, and maybe more bad news than good news.

Being an optimist, I will start with the good news. Medicare mispayments are about half the rate of several years ago, good news. And as the I.G. will point out, over 90 percent of all claims paid now contain no errors. In addition, the I.G. has given its first unqualified or clean audit opinion on HCFA's financial statement.

Well, I think that is a tribute to aggressive work by Medicare, the I.G., the additional tools we gave them, and commendable efforts by the medical community.

The bad news is we have made a little slip here. The steady progress has stopped. Where is that chart we had here? Just put it up here. I will have Peter hold it up here.

It is just to show that basically the estimated improper payments by type of error—I will not go over all of them—but as you can see in 1996, it was estimated at \$23.2 billion. It came down to \$20 billion. It had a great drop in 1998, thanks to the—to all the efforts, to \$12.6 billion. And last year, it has come back up a little bit.

So I am really concerned about that, and especially concerned in this area here called "Unsupported Services," where we had the biggest drop. And it has now come back up.

The others have kind of stayed kind of steady, especially in the improper coding and in the non-covered services. But in the "Unsupported Services," that—that is the concern that I have in how that has now come back up again.

The audit shows an increase of about \$900 million, about \$1 billion there. And \$13.5 billion in losses, again, I think is unacceptable. Again, that does not even include other losses due to poor administration and lax rules.

And, again, bad news, good news: Yesterday's Washington Post—I do not know if you saw this, Mr. Chairman, on the—the article on Connecticut General Life Insurance Company has agreed to pay about \$9 million to settle allegations that it overcharged Medicare for expenses.

The company allegedly billed for two pieces of paper when it was printing on both sides of the same sheet. And they are paying back about \$9 million to—to HCFA. Now, again, the good news is that they settled.

The bad is: I am wondering how much more of this is going on out there. So we do need to get back on track. And we need to do it now.

And I will be interested in hearing from Ms. DeParle about why that is going back up and what is going to be happening this year to try to get it back on track. I think we need to put some more focus on that and see what we can do.

Much can be done in a way that helps, not hinders, our health professionals, the honest ones out there that are hard-working. Provider education, I believe, is going to be necessary; simplifying paperwork.

And one of the items I will cover with you, Ms. DeParle, is competitive bidding. We gave you some money to do some trials. Of course, I personally wanted to move to competitive bidding right away, but that was not possible. So we have some trials out there.

I would like to know what is happening with competitive bidding, because, Mr. Chairman, I—excuse me for doing this, but I, again, this is a little syringe that I held up here 2 years ago. The VA was paying a \$1.89 for each one of them, 2 years ago. Medicare was paying \$2.93. It is still doing the same thing. Two years later, Medicare is still paying the same for that syringe. And I got to ask, again, why?

Here is a saline solution. These are two items I held up 2 years ago, and I keep track of them because I want to find out when we are going to get it—get it right. Medicare is paying \$7.90 a bottle. VA is paying \$2.38. Medicare is paying 223 percent more 2 years ago. It is the same thing today. They have not done a thing about stopping it.

And I am, again, wondering why. I mean—and I will continue to look at these and to find out when we are going to start paying as much for them as VA, because obviously if they are selling them to VA, they are making money. They are not losing money on this, by the way.

So as I said, we got to continue our efforts. We cannot back down.

I am looking forward to the testimony from our Inspector General and Ms. DeParle on how we can keep that slide from going down, and turn it around and get it going in the right direction.

Thank you very much, Mr. Chairman.

Senator SPECTER. Thank you very much, Senator Harkin.

Just a comment or two about the release from Dr. Nancy Hickey, immediate past president of the American Medical Association, dated today, saying, the audit is “irresponsible grandstanding,” her characterization, saying, “The Government must stop its punitive approach to accurate Medicare billing and must afford physicians the due process protections that are the right of all Americans,” complains about complexity of regulations. I think the regulations are complex, and simplification is in order.

And I know that the Congress and Senate would be very interested to hear from the American Medical Association on anything

specific in this respect, but to have a bland assertion that the Government must stop its punitive approach—collecting money in civil settlements is not a punitive approach.

Companies do not pay millions of dollars in settlement of cases that are not well-founded. And HCFA may be doing a lot of things and may have a lot of excessive regulations, but HCFA does not deny due process protections of the right of all Americans.

We still have a court system. And it is a little surprising to see the American Medical Association make an accusation about due process protections.

And if identifying this kind of fraud is grandstanding, we need a little more of it. But it is pleasant for a change to find the Executive Branch accused of grandstanding, instead of the Congress.

We will now proceed to our witnesses, Ms. DeParle, Ms. Brown, Ms. Aronovitz. Please step forward.

Our first witness—and the protocol always sort of amazes me, but the protocol has the Administrator of the Health Care Financing Administration, number one.

Ms. DeParle has had this very difficult job since November 10, 1997. Before joining HHS, Ms. DeParle was Associate Director for Health and Personnel at the White House Office of Management and Budget; from 1987 to 1989, served as Commissioner of Human Services in Tennessee; has a bachelor's degree from the University of Tennessee; and a law degree from Harvard.

Welcome, Ms. DeParle. We are going to use our customary timing of 5 minutes. And all statements will be made a part of the record in full. And that will leave the maximum amount of time for—

Senator CRAIG. Mr. Chairman, I do not need to make an opening statement. Let me thank you for the hearing and ask unanimous consent that my statement become a part of the record.

Senator SPECTER. Very good. We will—

Senator CRAIG. I may have to leave before this panel is—

Senator SPECTER. We would be glad to hear from you, Senator Craig, on an opening statement if you care to make one.

OPENING STATEMENT OF SENATOR LARRY CRAIG

Senator CRAIG. Well, it is important for us to deal with this issue, because we have had substantial problems in our State; and I have practitioners who are just simply saying: "If we are going to be put at this kind of risk, we are walking away from providing Medicare recipients the kind of services they need."

It is time that this has got to get corrected. The liability risk here for people who might make a clerical error is something that is unacceptable to me and to a lot of our folks in Idaho.

We have had meetings out there with the Idaho Medical Association. We have even brought them back here. And we have met with Health Care Finance Administration, trying to work these things out. And headway is being made.

PREPARED STATEMENT

So this is a timely hearing. I appreciate it. Enough said. Please proceed. Thank you.

Senator SPECTER. Thank you very much, Senator Craig.
[The statement follows:]

PREPARED STATEMENT OF SENATOR LARRY CRAIG

I would like to thank the Chairman for holding this hearing today. I would also like to thank the witnesses for taking the time to appear before the Committee to testify.

Last fall, I hosted a meeting between the Idaho Medical Association and Penny Thompson of the Health Care Finance Administration (HCFA). During this meeting various items were discussed, including many issues concerning the anti-fraud, waste and abuse programs that HCFA has implemented. I appreciate the good faith effort that HCFA has made to address the problems raised in that meeting. However, these issues are of major concern to the medical community in Idaho and I believe they need to be examined again—specifically, the establishing of a 800 telephone number to CIGNA for physician billing questions and, reducing the potential of HCFA's audit process to drive providers out of Medicare, thereby impeding rural Medicare patients' access to health care.

Idaho's Medicare Carrier, CIGNA, has moved its service center to Nashville, Tennessee. This service center is where physicians or their representatives call when they have a Medicare billing question. Idaho physicians and their staff need to have immediate and direct access to the carrier in an effort to clarify billing questions and minimize errors. The CIGNA automated response unit (ARU—a series of "press one for * * *") is time consuming and complicated. Long-distance phone costs may well be a deterrent to physicians asking legitimate questions and thus reducing billing errors.

I received a letter from A. Michelle Snyder, Director of HCFA's Office of Financial Management on February 17 in response to questions raised during the meeting between the IMA and HCFA about the establishment of a Carrier 800 number. The response indicated that HCFA is reviewing this proposal and working to establish toll free numbers for physicians, suppliers, and other providers.

I also am concerned about HCFA's billing audits. There is no doubt that the intent of Congress is, and continues to be, the elimination of proven fraud and abuse of the Medicare system. But it appears that HCFA's punitive approach in attacking physicians on unintended billing errors or mistakes can be counter productive, since it does not prevent future errors and can drive physicians away from the program.

At this point, Congress needs to assist HCFA in redirecting its focus—from one of a punitive nature against physicians, to one of educating those who make unintentional billing mistakes. HCFA has twisted the intent of Congress into a justification for harassing and intimidating a valuable sector of our economy.

I have discussed with HCFA staff your method of statistical sampling of patient charts and the extrapolation of errors found in those charts over the entire patient population to determine fines levied against physicians. I have very serious concerns that your extrapolation assumes guilt of a physician across their entire population.

Let me relay one example for the benefit of the committee:

In this case a physician has a total Medicare patient population of 525. CIGNA audited a sample of FIFTEEN charts, and through their statistical extrapolation, projected that the doctor had been overpaid to the tune of \$23,000. BUT the interesting part of this is that the TOTAL reimbursement across his entire Medicare population for that year was \$58,500. In effect, nearly HALF of the Medicare payments to this physician were deemed, retrospectively, to have been improperly paid * * * all through a statistical extrapolation from fifteen charts! I have to admit, this would greatly reduce my incentive to deal with HCFA if I were that physician.

Another example of this administration's overreaching approach to fraud and abuse is the (short lived) "Fraud Buster's Program" HCFA instituted. HCFA partnered with the AARP and essentially recruited their members as bounty hunters.

HCFA spent a good bit of time and money traveling the country conducting "Fraud Busters" seminars last year. Using the local AARP organizations to generate crowds, HCFA conducted half-day seminars geared toward convincing this vulnerable population that their doctors were committing Medicare fraud. HCFA distributed "freebies" to attendees of these meetings that included a T-shirt and a hat with an eye-catching "Fraud Busters" logo—and to make it easier for these poor victims to peruse fraudulent bills, a magnifying glass was provided by HCFA!

I bring up these examples to illustrate a point: Clearly, by these actions, HCFA has created a climate in which the physician is distrustful of this agency at best, and fearful at worst.

The state of Idaho is still largely rural in nature. Forty of Idaho's 44 counties are consistently classified as Health Professional Shortage Areas; practically every Idaho physician carries as many patients as he or she can possibly handle, and more are desperately needed. Many physicians employ one or two full-time office staff strictly to deal with Medicare and its complex and constantly-changing 16,000 pages of rules and regulations. As a direct result of the harassment they are enduring at the hands of HCFA, many physicians in my state are seriously analyzing whether they want to continue to see Medicare patients.

What shall I tell my Idaho constituents when they tell me they can no longer find a doctor that will see them? What do I say to the seniors who have grown to know and trust their local doctor, but must now find a new health care provider? And let me point out that in rural Idaho, the next doctor is not likely to be around the corner; patients may have to travel literally hours to the next community.

This has gone far beyond a fraud and abuse issue. It is now to the point that it is contributing to a worsening health care access problem for rural Americans. Doctors would rather NOT see Medicare patient at all than to endure the combination of administrative hassles, slow and low reimbursement for services, and the constant threat of IRS-like "gotcha" tactics from HCFA.

Again, I thank the Chairman and the panel of witnesses. I look forward to the benefit of the insight of today's witnesses. I will be asking questions today on these two issues and hope to gain a better understanding of what solutions HCFA will be implementing.

**STATEMENT OF HON. NANCY-ANN MIN DEPARLE, ADMINISTRATOR,
HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF
HEALTH AND HUMAN SERVICES**

Senator SPECTER. As I had said at the outset, we are going to try to conclude this hearing with slightly less than an hour. I am going to have to excuse myself shortly before 10:30. We have matters on the Senate floor.

Ms. DeParle, the floor is yours. Thank you for joining us.

Ms. DEPARLE. Thank you. Thank you, Mr. Chairman, Senator Harkin, and Senator Craig. Thank you for inviting me to be here today to address one of my highest priorities, which is our effort to get Medicare's financial house in order, and fight waste, fraud and abuse.

I also want to thank my colleagues, Inspector General June Gibb Brown—June Gibbs Brown, and Leslie Aronovitz from the General Accounting Office, for their highly constructive assistance in these efforts.

Senator Harkin, you said that you and Senator Specter have had a partnership when it comes to this issue. And I want you to know that the Inspector General and I have also had a partnership. And I think that is why we have made some of the progress that we have made.

I am pleased that, as the Inspector General's report points out, HCFA was able to obtain an unqualified audit opinion this year. That represents a lot of progress. As Senator Specter noted in fiscal year 1997 when the first audit was done, the auditors found the books to be in such a mess that they were unable to express an opinion.

They could not say whether Medicare's books reliably presented to the Congress and the taxpayers our assets and our liabilities.

We spent 3 years of very hard work confronting some unpleasant facts and difficult issues. We worked last year with independent CPA firms and the I.G. to clean up our books, so that we could delete bad debt and aggressively pursue other money that is owed to Medicare and to the Government.

We looked under every rock. We found things like a \$50 check to one of our contractors that was recorded as a \$70 million account receivable and things like that that had to be adjusted, some sloppy bookkeeping. And, of course, that meant that we need to do a lot more in overseeing our contractors.

And that is something that you alluded to, Senator Specter.

We are continuing a wide range of additional efforts to strengthen financial management and accounting systems. And importantly, we are developing an integrated general accounting system that we all agree is needed.

The audit also talks about system weaknesses and human errors that had to be addressed. I mentioned one of them. Another one was that this summer we found that monies that should have gone into one of our trust funds, through a human error, was posted to the other one.

And we found this ourselves. And while no taxpayer money was lost, clearly we have something there that has to be corrected, and we are in the process of doing that.

Meanwhile, Senator Harkin as you noted, our payment error rate is holding steady. And as you said, I agree that that is both good and bad news.

The rate is a lot better than it was when it was measured first 4 years ago. It is proof, I think, that last year's dramatic reduction is not a one-time phenomenon, but as I was talking to June about it earlier today, I said it is—I think last year we both thought we had turned a corner.

And what we now see is around that corner is a long, dark hallway. And we have got to really focus on what is in that hallway. And I think this year's sample gives us a blueprint, and you held it up.

We have to focus on the red. Forty-one percent of the problem that we have in this year's audit is what we call documentation errors, and the Inspector General can explain at more length what that is.

It is a little different than it was in the beginning. In the beginning, as you will recall we had a lot of claims where we would go back to say, "OK. Where is the documentation for this?" And the Inspector General would go back time after time, and nothing would be produced.

Now, it is not so much that nothing is produced, but they produce something that does not support the expenditure that they made of Medicare's money. And it is in three areas. It is in home health. It is in durable medical equipment. It is in physicians.

So we are going to have an aggressive effort there. And I am going to tell you it is going to start with me personally contacting all 700,000 physicians who participate in the Medicare Program, all 9,000 home health agencies and 126,000 medical equipment providers to address this and explain to them how to avoid common errors that they are making.

We are also going to test new documentation guidelines that will be simpler and easier, Mr. Chairman, for physicians to use. And we are increasing the level of claims review and especially pre-payment medical review, which is the most effective thing in dealing with this problem.

Last year, Senator Harkin, you told me that we should not take a victory lap yet. And I agree with you. And let me assure you that we are not taking a victory lap.

I personally will not be satisfied until our books are a model of good accounting and our error rate is zero, but we have made significant progress. And I want to sustain it. And with your continued support and the support of the other members of this Committee, I think we will be able to do so.

Thank you.

Senator SPECTER. Very good. Thank you very much, Ms. DeParle. [The statement and questions with answers follow:]

PREPARED STATEMENT OF HON. NANCY-ANN DEPARLE

Chairman Specter, Senator Harkin, distinguished Subcommittee members, thank you for inviting me to discuss our progress in getting Medicare's financial house in order. I would also like to thank the HHS Inspector General (IG) and General Accounting Office (GAO) for their valuable assistance to us in this effort.

The Clinton Administration has a zero tolerance policy for health care fraud, waste, and abuse. In 1995, we launched Operation Restore Trust, a ground-breaking anti-fraud project aimed at coordinating federal, state, local and private resources in targeted areas. The result is a record series of investigations and convictions, as well as new management tools to fight improper payments.

Since 1996, we have built on these efforts with findings from the Chief Financial Officer's audits through a series of aggressive actions to prevent improper payments and strengthen our financial integrity. The audit findings and GAO reviews serve as roadmaps directing us to needed improvements. We are attacking financial management problems with the same focus and energy that we used to meet our Year 2000 computer challenge, and we intend to be as successful in this as we were in Y2K.

We have seen tangible results from our efforts to address audit findings each year. This year, for the first time, the auditors are able to give us a clean opinion. And the claims payment error rate is holding steady at about half of what it was in 1996, even though this year's sample includes more claims for problem areas such as home health and medical equipment. These results show that our progress is not a one-time phenomenon but something sustainable on which we can build.

We are taking several new steps to further protect Medicare's financial integrity and bring the claims payment error rate down. Key among these are efforts to determine an error rate for every contractor that pays these claims. This will help us focus on specific problems in a far more targeted way than we can with the national error rate, which is extrapolated from claims for just 600 beneficiaries.

Another critical area includes efforts to help providers document and file claims correctly. We will test new documentation guidelines that should be easier for physicians to use. We will expand outreach and education programs, such as computer-based learning modules, that have proven effective in helping providers file claims correctly. And we will contact all physicians, home health providers, and durable medical equipment suppliers in the Medicare program to address documentation problems and explain how to avoid common errors.

We also can expect to see more impact from the many program integrity efforts that we initiated this past year through our comprehensive program integrity plan and other steps.

- We hired special contractors to focus solely on preventing improper payments.
- We greatly strengthened contractor oversight through tighter performance evaluation standards, national evaluation teams, and mandatory corrective action plans.
- And we continue to seek contracting reform legislation so we can use the same contracting rules as other government agencies and expand the range of firms capable of serving Medicare and protecting taxpayer dollars.

We are aggressively addressing financial management issues identified by us, the IG, GAO, and independent accounting firms with which we have contracted. Most of these issues have their roots in the system established in the 1965 Medicare law, whereby Medicare must contract with private health insurance companies to process and pay claims. We have made significant progress, and we have an ambitious array of actions already planned or underway that are consistent with the GAO re-

port's recommendations. I am determined that Medicare and its contractors meet the same high standards of accounting required of major private sector corporations.

BACKGROUND

Medicare pays more than \$200 billion to one million health care providers for services provided to nearly 40 million seniors and disabled Americans annually. The Government Management Reform Act has required annual audits each year since fiscal 1996, including review of a statistical sample of Medicare claims. That year a 14 percent claims payment error rate and several weaknesses in financial management were identified. We have been working diligently to address these issues ever since.

In response to the fiscal 1996 audit, we took several actions to address the most serious problems first. We contracted with Ernst & Young to help us clean up our accounts payable. We funded an audit to address concerns about the Social Security Administration process for withholding Supplemental Medical Insurance Premiums.

We also initiated several other actions to address the error rate that included:

- increasing the level of claims review and the number of physician medical directors who lead claims review activities for contractors;
- expanding the number and scope of computer “edits” that identify improper claims before they are paid;
- developing stricter enrollment safeguards to keep illegitimate providers from billing Medicare; and
- organizing a national fraud, waste, and abuse conference and using lessons learned to begin developing a comprehensive program integrity plan.

The fiscal 1997 audit verified our success in addressing issues with our accounts payable and the Social Security Administration. Also that year, the payment error rate dropped to 11 percent.

Following the fiscal 1997 audit, we took action to clarify our handling of cost reports and the Medicaid payables and receivables to the auditors' satisfaction, and made progress in the remaining areas of concern raised by the auditors.

We also:

- made further increases in the level of claims reviews;
- began conducting site visits nationwide to ensure that durable medical equipment providers were in fact, legitimate businesses; and
- set stricter enrollment criteria to keep unscrupulous medical equipment providers and home health agencies out of the program.

Strengthening contractor oversight

Among the most important actions we took following the fiscal 1997 audit were steps to substantially strengthen oversight of the private insurance companies that, by law, process Medicare claims and thus carry out critical financial management functions. We consolidated responsibility for contractor management by establishing the new position of Deputy Director for Medicare Contractor Management. And we created a Medicare Contractor Oversight Board to set policy regarding contractor-related activities. These steps are proving to be critical as we move forward to address remaining issues.

The fiscal 1998 audit revealed more substantial results from our actions. The payment error rate was down to 7.1 percent, and only one area—accounts receivable—kept us from receiving a clean opinion.

In response to the fiscal 1998 audit, we hired independent Certified Public Accounting firms to assist us in an extensive analysis of accounts receivables that validated more than 80 percent of the outstanding debt. As a result, we identified \$2.6 billion in outstanding receivables, some as much as 10 years old, most of which should have been paid by other insurers.

As required by the Debt Collection Improvement Act, we will aggressively pursue this debt and, when appropriate, refer cases to the Treasury Department for further collection activity and litigation. In accordance with policy of the federal Chief Financial Officers' Council, we are removing these receivables from our financial statements so the statements reflect accurate economic value.

We also removed about \$300 million in debt that is as much as 10 years old with no potential for collection from our financial statements. Some of these debts exceed the statute of limitations for collection.

Our accountants also identified \$1.3 billion in adjustments from the books of our claims processing contractors, and these also were removed from our financial statements. We are requiring these contractors to implement corrective actions so they comply with generally accepted accounting principles and prevent these types of errors from recurring.

Also in the past year we:

- implemented our comprehensive program integrity plan, which details our overall strategy to reduce waste, fraud and abuse;
- hired independent Certified Public Accounting firms to analyze internal control systems at 25 of the largest and highest-risk Medicare contractors, representing 80 percent of Medicare fee-for-service payments;
- created standardized reporting and evaluation protocols and used national review teams to evaluate contractors' fraud and abuse efforts and other key functions;
- directed each contractor to implement corrective action plans to ensure that they can track funds more accurately;
- notified the contractors of our intent to amend our contracts with them to require details and time frames for correction of each deficiency identified;
- hired our first-ever national contractor to ensure Medicare does not pay claims that private insurance companies should pay;
- initiated steps to develop an integrated general ledger system to standardize the accounting systems used by all contractors; and
- created and filled a new high-level management position to coordinate the agency's business plans to further strengthen financial controls.

FISCAL 1999 RESULTS

Our Government Performance and Results Act goal for 1999 was an error rate of 9 percent. The new fiscal 1999 payment error rate estimate is 7.9 percent, which is not a statistically significant change from the fiscal 1998 error rate. Due to the limited size and variance of the sample, the true error rate could range from 5.4 to 10.6 percent. We are committed to achieving our goal for 2002 of 5 percent.

The error rate plateau shows that our actions have achieved sustainable improvement. And it is noteworthy that the rate remained stable even though the fiscal 1999 sample included more home health and durable medical equipment claims—areas where problems have been more common.

The clean audit opinion reflects our success in improving Medicare's financial systems to increase the efficiency and accuracy of our financial statements in accordance with standard accounting practices. This is an essential step in assuring that Medicare's financial status is accurately portrayed so that the most effective subsequent steps can be taken toward sounder day-to-day financial management. Several of these on-going reforms directly address contractor issues.

Contractor-specific error rates

While the national error rate has helped us focus our efforts on preventing improper payments, we need stronger tools to uncover the real problem areas. Key to this effort is our proposal to develop contractor-specific error rates. For each contractor, we will conduct reviews for a statistically valid sample of claims and determine whether the contractor paid the claim accurately. The review will determine whether health-care providers were underpaid or overpaid for the sampled claims. The results will reflect not only the contractor's performance, but also the billing practices of the health-care providers in their region. Contractors will then develop targeted corrective action plans to reduce payment errors through provider education, claims review and other activities.

We will establish baselines and then track each contractor's rate of improvement. The results will guide contractor's plans to reduce errors much as the overall Medicare error rate has guided our national improvement efforts. We will begin this summer by determining error rates for the companies that process nearly 50 million claims each year for medical equipment and supplies for beneficiaries nationally, and we plan to perform similar evaluations for all claims-processing contractors.

Additional efforts focused on contractors include:

- Strengthening contractor oversight.*—The President's fiscal year 2001 budget requests \$48 million for new positions at the contractors and HCFA to tighten financial controls and ensure a swift, coordinated response to waste, fraud, and abuse. The budget also includes a provision for HCFA to competitively contract with a qualified entity to audit and evaluate financial management systems.
- Issuing contractor report cards.*—We are working with the IG to create report cards on each contractor's performance against specific goals and criteria. Contractors that perform poorly and fail to improve risk losing their Medicare business.
- Requiring corrective action plans.*—We have already requested corrective action plans from contractors for problems identified in the fiscal 1999 audit. We have developed written procedures for requesting, tracing, and disseminating such corrective action plans, including time frames for evaluating them. Each contractor must include a detailed description of each problem, specify details of

actions and time frames to resolve them, and submit quarterly reports on their progress. We plan to hire a Certified Public Accounting firm to evaluate how effective these corrective actions are. And, we will include review of corrective action plan effectiveness in our standardized Contractor Performance Evaluation process.

- Strengthening Regional Office coordination.*—We are consolidating responsibility for contractor management among our 10 regional offices by establishing four Consortium Contractor Management Officers. They will be accountable for management of specific contractors and oversee staff with primary responsibility for contractor management.
- Seeking contracting reform.*—We continue to seek contracting reform legislation to allow Medicare to use all firms capable of processing claims and protecting program integrity. Existing law requires Medicare to use only health insurance companies to process claims, and allows some providers to choose their claims processor. This has hampered our program integrity efforts, as the commitment to these efforts has varied widely among these contractors. And some of these insurance companies themselves have been convicted of violating Medicare program integrity. The IG and GAO have agreed that we need to create an open marketplace so we do not have to rely on a steadily shrinking pool of insurance companies and can bring Medicare contracting in line with standard contracting procedures used throughout the Federal government.

Financial management

We are also taking several steps to address financial management issues. These include:

- Developing an integrated financial management system.*—We continue to work towards an integrated financial management system to standardize the accounting systems used by all contractors. The project, which will make it easier to coordinate and reconcile data, is scheduled for completion by 2004, pending the results of the assessment phase currently underway. The President's fiscal year 2001 budget requests \$7 million to support this essential project.
- Consolidating accounting functions.*—We are consolidating all accounting and CFO Act reporting functions in one organization. And we are establishing a new division to concentrate on internal controls and risk adjustment, and ensure that procedure guidelines and accounting policies are written, designated, and implemented.
- Assessing staff needs.*—We are engaged in an agency-wide planning effort to assess staffing needs, including those for financial management. We also will consult with outside experts to help us develop staff skills in financial analysis and other pattern analysis techniques that can help identify potential problems. In the meantime, we have initiated a short-term project to organize regional office staff currently involved with contractor oversight in order to facilitate better national coordination of efforts. And we are assessing other resource needs for optimal contractor oversight.
- Improving guidance to contractors.*—We are developing a financial management internal control manual with standards for evaluating contractors' financial management performance. We are working with an outside consultant who plans to seek further input from contractors, and then create a database that we can post on the Internet with all our financial management guidance and instructions for contractors. We expect this to be completed by September. In the meantime, we will clarify for contractors our instructions for allocating cash receipts between the two Medicare trust funds. We also will update our manual of instructions for contractors on a yearly basis to incorporate results from oversight and evaluation efforts by us, the IG, and GAO.
- Developing comprehensive financial management plan.*—We are developing a comprehensive financial management business plan to identify the strategies that will achieve our objectives. This is being led by our newly created position of Associate Director for CFO Audits and Internal Controls, and should be completed this summer.

Error rate reduction

To bring the payment error rate down further, we are:

- Ensuring proper payment.*—We will continue to aggressively work to reduce the payment error rate to below 5 percent by fiscal 2002 through our comprehensive program integrity plan and other efforts. Although Medicare pays virtually all claims correctly based on the information submitted, improper payments occur for reasons such as insufficient documentation, lack of medical necessity, and

improper coding by providers. The error rate does not measure fraud, but can include improper payments related to fraudulent conduct.

- Focusing on inpatient care.*—Medicare’s physician-led Peer Review Organizations are working with hospitals to investigate, correct, and prevent claims that are improperly coded, insufficiently documented, or for unnecessary or uncovered services. Our new contracts with them include strong financial incentives for them to reduce improper payment rates for inpatient care.
- Hiring special program integrity contractors.*—Using specific contracting authority provided by HIPAA, we last year chose 13 companies, including financial management and technology companies, as our first-ever contractors devoted to protecting the Medicare Trust Fund. These contractors, who have health care expertise, will help us tackle key tasks, including audits, medical reviews, data analysis, site visits, and provider education.
- Expanding the correct coding initiative.*—We will continue to expand the correct coding initiative, which uses roughly 100,000 computer edits to identify improper claims before Medicare pays them. Begun in 1994, the initiative prevents more than \$250 million in improper payments each year.

Working with providers

We also are continuing efforts to help providers file and document claims correctly. This is particularly important, as the current audit shows that the error rate plateaued largely due to a sharp increase in documentation problems since last year. Missing or inadequate documentation accounted for 41 percent of errors in the current audit, which is more than double the rate of such problems found last year.

To help providers file claims properly, we are:

- Testing new documentation guidelines.*—We will this year begin testing new guidelines for physicians on how to document evaluation and management services, which constitute the majority of Medicare claims. The guidelines will help ensure Medicare pays claims correctly while minimizing the paperwork burden for doctors.
- Expanding provider education.*—We will expand efforts to help doctors, hospitals, and other providers learn how to properly file and document claims. This includes innovative computer courses on our web site on the proper filing and documentation of claims, as well as satellite broadcasts and other efforts.
- Contacting key providers.*—We will directly contact all physicians, home health providers, and durable medical equipment suppliers in the Medicare program to address documentation problems and explain how to avoid common errors.
- Initiating Progressive Corrective Action.*—We are undertaking a new initiative in which we will share more feedback with providers, both on an individual and community level, about how to correct and prevent the types of errors identified in medical review of claims. We believe this can have a substantial impact in reducing improper claims among the vast majority of providers who make only honest errors.

CONCLUSION

Protecting program integrity and strengthening financial management and contractor oversight are our top priorities now that we have met our Year 2000 obligation. The findings of this year’s audit and the GAO report on financial management will once again serve as a roadmap guiding us to further improvements.

We look forward to working with Congress, our IG and GAO colleagues, and our contractor and provider partners to ensure that we meet our obligation to pay claims properly, fight fraud, waste, and abuse, and responsibly manage Medicare finances.

QUESTIONS SUBMITTED BY SENATOR ARLEN SPECTER

HHS INSPECTOR GENERAL STUDY

Last year, the Committee urged the Office of the Inspector General, in cooperation with HCFA, to study the use of private recovery specialists with respect to Medicare overpayments, and to inform the Committee on its findings.

Question. Is this study underway? When would you expect to report to the Committee with the findings?

Answer. We understand that the Office of the Inspector General (OIG) is in the process of conducting this study, and would defer to the OIG regarding their expected completion date.

RECOVERY SPECIALISTS: HCFA AND VA APPROACH

Question. Last year, the Committee encouraged HCFA to “explore the use of companies to recover mispayments that have significant experience providing this service to major commercial insurers.” (Copy of language previously sent via facsimile).

What progress has HCFA made in contracting directly with overpayment recovery firms? Do you require any legislative language? Have you looked at the VA program to see if some of their processes and contractors may be of assistance to HCFA in recovering overpayments? What is your position on the VA manner of contracting with such firms (i.e., contingent payments)?

Answer. According to our Office of the General Counsel, we do not have the authority, under current law, to pay Medicare Integrity Program (MIP) recovery contractors on a contingent fee basis. To do so would require a legislative change. Although we are familiar with the VA manner of contracting with overpayment recovery firms, we have not thoroughly examined their processes in light of the fact that we do not have the legal authority to institute such a system under current law.

 QUESTIONS SUBMITTED BY SENATOR JON KYL

Background: In 1987, Congress authorized the Medicare Community Nursing Organization (CNO) demonstration project to test the ability of nursing organizations to provide quality health care services in home and community-based settings, without requiring beneficiaries to join HMOs. Currently, demonstration projects operate in Arizona, Minnesota, New York and Illinois.

In the Balanced Budget Reconciliation Act of 1999 (BBRA), Congress authorized a two-year extension of the CNO project with the caveat that payments to the program be “budget neutral.”

The BBRA passed in November 1999 and to date, HCFA has not informed the CNOs of the new payment methodology. Moreover, HCFA has stated that any new payment system will be retroactive to January 1, 2000. Lastly, as a result of the delay, the CNOs have not yet received reimbursement in 2000. According to the Tucson CNO site, their last payment was in December.

QUESTIONS FOR HCFA

Question. What progress has HCFA made in developing a budget neutral payment methodology, and when do they expect to inform the CNO sites of the new methodology? *Question:* When can the CNO sites expect to begin receiving their payments?

Answer. On May 3, 2000 HCFA advised the CNO sites of their budget neutral rates. The CNOs have been paid since January 2000 based on the method used before the BBRA’s requirement that rates must be budget neutral. They will continue to be paid those rates through June 2000. Beginning in July 2000 we will implement a revised rate schedule that meets the BBRA’s budget neutrality requirement. The new rates incorporate a relatively small reduction for the period of July–September 2000. Further reductions will be applied in each additional calendar quarter to attain budget neutrality for the 2-year extension period. Rates must be significantly lower in the later months of the extension period in order to meet the BBRA’s required budget neutrality reduction over the entire extension period, as well as recapture any overpayments that result from delaying the application of the full reduction.

We believe this schedule is the best approach to meeting the requirements of the BBRA’s budget neutrality requirement because it provides a 5month time period with either no rate reductions or minimal rate reductions, May–September, for sites to assess the situation and make decisions about their continued participation.

This is the seventh year of operation for the CNO demonstration, which began in 1994. Originally designed as a 3-year demonstration, it was extended twice prior to the BBRA extension. Two interim evaluations, in 1996 and 1998, reported that the CNO model, as structured under this demonstration, resulted in higher Medicare costs but could not demonstrate a positive impact on health outcomes or behaviors. The recently completed final report, which is based on data from 36 months of CNO operation, confirmed this finding. The BBRA provided for an additional 2-year extension subject to a requirement that the demonstration be budget neutral over the 2-year extension period, encompassing years 2000–2001.

STATEMENT OF HON. JUNE GIBBS BROWN, INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

ACCOMPANIED BY JOSEPH E. VENGRIN, ASSISTANT INSPECTOR GENERAL FOR AUDIT OPERATIONS AND FINANCIAL STATEMENT ACTIVITIES

Senator SPECTER. We now turn to Ms. June Gibbs Brown, the Inspector General of the Department of HHS, who has a phenomenal record of being the Inspector General of the Navy's Pacific Fleet, Interior Department; 1979 to 1981 NASA; and the Department of Defense from 1987 to 1989.

Ms. Brown received her bachelor's and master's in business administration from Cleveland State University, and her law degree from the University of Denver.

In addition, she is a graduate of Harvard's Advanced Management program and a CPA.

You bring a lot of credentials to the table, Ms. Brown. Thank you for joining us. And the floor is yours.

Ms. BROWN. Thank you, Mr. Chairman, Senator Harkin, and Senator Craig.

I have with me today, Joseph E. Vengrin. He is Assistant Inspector General for Audit Operations and Financial Statement Activities.

I am pleased to report to you that HCFA's progress in reducing Medicare payment errors and presenting reliable financial information has been pretty consistent, even though we have a plateau this year as far as the error rate is concerned.

I would like to begin by acknowledging the cooperation and support we received by both the Department and HCFA and the General Accounting Office in cleaning up a lot of—of the errors that had been occurring.

HCFA's assistance in making available the medical review staff and—at the Medicare contractors and peer review organizations was invaluable.

We also worked closely with GAO in carrying out its responsibility for auditing the consolidated financial statements of the Federal Government.

My statement today will focus first on our review of Medicare payment errors, which we conducted at HCFA's request and then on fiscal year 1999 financial statements.

Our review included a statistical selection of 5,223 Medicare claims from a population of \$169.5 billion in fiscal year 1999 fee-for-service claim expenditures.

Payments to providers for 1,034 of those claims did not comply with Medicare laws and regulations. By projecting those sample results, we estimated that fiscal year 1999 net payment errors totaled about \$13.5 billion nationwide, or about 7.97 percent of the total Medicare fee-for-service payments. This is the mid-point of the estimated range at the 95 percent confidence level of \$9.1 billion to \$17.9 billion or about 5.4 to 10.6 percent.

I go into that detail, only because I want to assure that everybody understands this is a sampling technique, and that is the reason why I do not say there is a statistical difference between last year and this year. It falls within the same range.

In past years, the improper payments could range from inadvertent mistakes to outright fraud and abuse. And that is true of this year.

It should be noted that medical personnel detected almost all of the improper payments in our sample. When these claims were submitted for payment to Medicare contractors, they contained no visible errors.

Now, the 4-year analysis substantiates HCFA's continued—continued vigilance in monitoring and reducing payment errors. This year's \$13.5 billion estimate is, in fact, \$9.7 billion less than that for 1996, which you have pointed out.

In addition, our audit results clearly show that the majority of health-care providers submit claims to Medicare for services that are medically necessary, billed correctly, and sufficiently supported.

Both in fiscal years 1998 and 1999, we estimated that over 90 percent of the fee-for-service payments met Medicare reimbursement requirements. However, our analysis demonstrates that unsupported or medically unnecessary services remain pervasive problems. These type of errors accounted for more than 70 percent of the total improper payments over the 4 years.

Our chart, which is also attached to the written testimony, demonstrates the trends in improper payments by the major type of errors that we found.

The red area indicates unsupported services, where we saw a substantial increase. I would like to just comment on unsupported services, because that is made up of two things.

Where the documentation does not support the service: The documentation is the medical record. So when we are saying that there should be documentation, we are not saying somebody did not cross a "t" or—or use correct grammar or something else. We are saying that there is nothing in the medical record that would support the service that was being billed.

And the other percentage is where no medical record was provided. Now, we have gone out at least three times and at HCFA's request, went four and five times, even made site visits in some cases, to get the medical record. So when I say there—no medical record was provided, it is very likely that there was no medical record to support the payment. It is not just a payment error of some kind that did not agree.

The blue area on the chart that Senator Harkin held up was medically unnecessary services. That is a continuing problem. The green was incorrect coding; and finally, the yellow, non-covered service and other miscellaneous errors.

The Medicare specifically requires providers to maintain records that contain sufficient support to justify the diagnosis, the admission, and other services provided.

As the second largest error category this year, medically unnecessary services totaled \$4.4 billion. For these errors, medical reviewers found enough documentation in the medical records to make an informed decision that the services were not medically necessary.

These type of errors in inpatient prospective payment systems, or PPS, hospital claims were significant in all 4 years.

Incorrect coding was the third largest error category. Physician and inpatient PPS claims accounted for 90 percent of the coding er-

rors over the 4 years. For most of these errors, medical reviewers determined that the documentation submitted by providers supported a lower reimbursement code.

Turning now to the audit of the financial statements for fiscal year 1999, we are pleased to issue the first unqualified or clean opinion, both for HHS and for HCFA. In achieving this important milestone, HCFA has successfully resolved billions of dollars in problems that affected our previous audit opinions; in particular, problems in Medicare accounts receivables, which are debts that providers owed to HCFA.

There have been systemic and longstanding problems in this area. This year, HCFA embarked on an extensive effort to validate and document receivables with the assistance of both my office and two public accounting firms.

The validation effort, together with HCFA's aggressive action to require that contractors maintain support for this debt, enabled us to conclude that the receivables balance was fairly presented and sufficiently documented for the first time in 4 years.

However, the underlying internal control environment and accounting systems at the Medicare contractors still needs substantial improvement, such as even a basic double-entry accounting system, a bookkeeping system that you would find at any gas station, was not available at the Medicare contractors.

Adequate checks and balances to promptly detect errors and irregularity—as my colleague stated, where a check number was picked up in the millions of dollars rather than a \$50 claim. There is no double entry system to identify this error when it happens, so that can be carried on the books for years.

These control weaknesses impair HCFA's ability to reliably report activity related to Medicare debt, and they increase the risk that future debt may not be collected timely.

Our report also discusses our concern that HCFA has not yet established adequate financial controls, such as routine accounting analyses to detect accounting aberrations, or sufficient controls over Medicare electronic data processing systems.

To briefly summarize, Mr. Chairman, we are greatly encouraged at HCFA's sustained success in reducing Medicare payment errors and by the important progress made in resolving the prior year's financial reporting problems.

We remain concerned, however, that inadequate internal controls over accounts receivable leaves the Medicare Program very vulnerable to potential loss or misstatement.

As HCFA begins a lengthy process to integrate its accounting system with the Medicare contractor systems, internal controls must be strengthened to ensure that the debt is accurately recorded, and adequate debt collection is in place.

With the year 2000 remediation challenge successfully completed, we urge HCFA to focus on these critical internal controls, while continuing its efforts to reduce the payment errors and ensure provider integrity.

I appreciate the opportunity to appear and will be glad to answer any questions.

Senator SPECTER. Thank you very much, Ms. Brown.

[The statement follows:]

PREPARED STATEMENT OF HON. JUNE GIBBS BROWN

Good morning, Mr. Chairman. I am June Gibbs Brown, Inspector General of the Department of Health and Human Services. With me today is Joseph E. Vengrin, Assistant Inspector General for Audit Operations and Financial Statement Activities. I am pleased to report to you on the Health Care Financing Administration's (HCFA) progress in reducing Medicare payment errors and in presenting reliable financial information.

My statement today will focus first on our audit of fiscal year (FY) 1999 Medicare fee-for-service payments. This was our fourth annual estimate of the extent of fee-for-service payments that did not comply with laws and regulations. As part of our analysis, we profiled all 4 years' results and identified specific trends, where appropriate, by the major types of errors found and the types of health care providers whose claims were erroneous. Then I will briefly describe the significant findings of our audit of HCFA's fiscal year 1999 financial statements, which is required by the Government Management Reform Act of 1994. The purpose of financial statements is to accurately portray agencies' financial operations, including what they own (assets), what they owe (liabilities), and how they spend taxpayer dollars. The purpose of our audit was to independently evaluate the statements.

Before I begin, I would like to acknowledge the cooperation and support we received from the Department, HCFA, and the General Accounting Office (GAO). The HCFA's assistance in making available medical review staff at the Medicare contractors and the peer review organizations (PRO) was invaluable in reviewing benefit payments. Also, I want to point out that we worked closely with GAO, which is responsible for auditing the consolidated financial statements of the Federal Government. The Department is one of the most significant agencies included in these Governmentwide statements.

MEDICARE PAYMENT ERRORS

Overview

With expenditures of approximately \$316 billion, assets of \$212 billion, and liabilities of \$39 billion, HCFA is the largest component of the Department. The HCFA is also the largest single purchaser of health care in the world. In 1999, Medicare and Medicaid outlays represented 33.7 cents of every dollar of health care spent in the United States. In view of Medicare's 39.5 million beneficiaries, 870 million claims processed and paid annually, complex reimbursement rules, and decentralized operations, the program is inherently at high risk for payment errors.

Like other insurers, Medicare makes payments based on a standard claim form. Providers typically bill Medicare using standard procedure codes without submitting detailed supporting medical records. However, regulations specifically require providers to retain supporting documentation and to make it available upon request.

As part of our first audit of the HCFA financial statements for fiscal year 1996, we began reviewing claim expenditures and supporting medical records. At HCFA's request, we have continued these reviews because of the high risk of Medicare payment errors and the huge dollar impact on the financial statements (\$169.5 billion in fiscal year 1999 fee-for-service claims).

Our primary objective each year has been to determine whether Medicare benefit payments were made in accordance with Title XVIII of the Social Security Act (Medicare) and implementing regulations. Specifically, we examined whether services were (1) furnished by certified Medicare providers to eligible beneficiaries; (2) reimbursed by HCFA's Medicare contractors in accordance with Medicare laws and regulations; and (3) medically necessary, accurately coded, and sufficiently supported in the beneficiaries' medical records.

Sampling methodology

To accomplish our objective, we used a multistage, stratified sample design. The first stage consisted of a selection of 12 contractor quarters for fiscal year 1999. The selection of the contractor quarters was based on probabilities proportional to the fiscal year 1998 fee-for-service benefit payments. The second stage consisted of a stratified, random sample of 50 beneficiaries from each contractor quarter. The resulting sample of 600 beneficiaries produced 5,223 claims valued at \$5.4 million for review.

For each selected beneficiary during the 3-month period, we reviewed all claims processed for payment. We first contacted each provider in our sample by letter requesting copies of all medical records supporting services billed. In the event that we did not receive a response, we made numerous follow-up contacts by letter, telephone calls, and/or onsite visits. Then medical review staff from the Medicare contractors (fiscal intermediaries and carriers) and PROs assessed the medical records

to determine whether the services billed were reasonable, adequately supported, medically necessary, and coded in accordance with Medicare reimbursement rules and regulations.

Concurrent with the medical reviews, we made additional detailed claim reviews to determine whether (1) the contractor paid, recorded, and reported the claim correctly; (2) the beneficiary and the provider met all Medicare eligibility requirements; (3) the contractor did not make duplicate payments or payments for which another primary insurer should have been responsible under Medicare secondary payer requirements; and (4) all services were subjected to applicable deductible and co-insurance amounts and were priced in accordance with payment regulations.

Sample results

Through detailed medical and audit review of a statistical selection of 600 beneficiaries nationwide with 5,223 fee-for-service claims processed for payment during fiscal year 1999, we found that 1,034 claims did not comply with Medicare laws and regulations. By projecting these sample results, we estimated that fiscal year 1999 net payment errors totaled about \$13.5 billion nationwide, or about 7.97 percent of total Medicare fee-for-service benefit payments. This is the mid-point of the estimated range, at the 95 percent confidence level, of \$9.1 billion to \$17.9 billion, or 5.4 percent to 10.6 percent, respectively. As in past years, the payment errors could range from inadvertent mistakes to outright fraud and abuse, such as phony records or kickbacks. We cannot quantify what portion of the error rate is attributable to fraud.

Medical professionals detected 92 percent of the improper payments. When these claims were submitted for payment to Medicare contractors, they contained no visible errors. It should be noted that the HCFA contractors' claim processing controls were generally adequate for (1) ensuring beneficiary and provider Medicare eligibility, (2) pricing claims based on information submitted, and (3) ensuring that the services as billed were allowable under Medicare rules and regulations. However, their controls were not effective in detecting the types of errors we found.

Historical analysis of error rates

Our analysis of payment errors from fiscal year 1996 through fiscal year 1999 demonstrates HCFA's continued vigilance in monitoring and reducing payment errors. This year's \$13.5 billion estimate is, in fact, \$9.7 billion less than the fiscal year 1996 estimate. In addition, our audit results clearly show that the majority of health care providers submit claims to Medicare for services that are medically necessary, billed correctly, and sufficiently supported. For both fiscal years 1998 and 1999, we estimated that over 90 percent of fee-for-service payments contained no errors. This is a very positive reflection on the diligence of the health care provider community to comply with Medicare reimbursement requirements. However, our analysis shows that unsupported and medically unnecessary services continue to be pervasive problems. These two error categories accounted for more than 70 percent of the total improper payments over the 4 years.

The attached chart presents an historical analysis of improper payments by major error categories: (1) unsupported services, (2) medically unnecessary services, (3) incorrect coding, and (4) noncovered services and miscellaneous errors.

Unsupported services

Unsupported services represented the largest error category every year except fiscal year 1998, when they dropped dramatically. This year we saw a \$3.4 billion increase over last year's estimate; however, these errors remained below the levels found in FYs 1996 and 1997.

Medicare regulation, 42 CFR 482.24(c) specifically requires providers to maintain records that contain sufficient support to justify diagnoses, admissions, treatments performed, and continued care. When the records were insufficient or missing, medical reviewers could not determine whether services billed were actually provided to Medicare beneficiaries, the extent of the services, or their medical necessity. It should be noted that HCFA upheld 99 percent of the overpayments identified in the fiscal year 1998 sample and recovered about 87 percent; the remaining 13 percent has not been collected due to an ongoing investigation.

This year's estimated \$5.5 billion in unsupported services consisted of \$4.5 billion in claims for which medical review staff found that the documentation was insufficient to support the billed services and \$1 billion in claims for which no documentation was provided. These errors were largely attributable to three provider groups: home health agencies (\$1.7 billion), durable medical equipment (DME) suppliers (\$1.6 billion), and physicians (\$1.1 billion).

Some examples of unsupported services follow:

- A home health agency was paid \$84 for a psychiatric nurse visit to a patient. While documentation evidenced that the visit had been made, neither the patient's plan of care nor the doctor's orders authorized the home health agency to provide the psychiatric nursing care. As a result, medical reviewers denied the payment.
- A DME supplier was paid \$815 for an enteral feeding supply kit, a gastrostomy tube, and 380 units of enteral formula. Medical review staff concluded that the supplier's documentation was not sufficient to support the claim because the records did not include physician progress notes, laboratory values, radiological studies ordered, or weight charts. In addition, because the delivery ticket did not provide individual beneficiary information, medical reviewers were unable to determine what products were delivered and to whom. As a result, the total payment was denied.
- A physician was paid \$28 for a hospital visit. However, medical reviewers found a note in the medical records which stated, "Pt [patient] not in room." Because a patient encounter could not be verified and no other documentation substantiated the visit, the payment was denied.

Medically unnecessary services

Medically unnecessary services constituted a significant part of the historical error rate: 37 percent of the improper payments in both fiscal years 1996 and 1997, 56 percent in fiscal year 1998, and 32 percent in fiscal year 1999. For these errors, medical reviewers found enough documentation in the medical records to make an informed decision that the medical services or products received were not medically necessary. As in past years, Medicare contractor or PRO medical staff made decisions on medical necessity using Medicare reimbursement rules and regulations. They followed their normal claim review procedures to determine whether the medical records supported the claims.

These types of errors in inpatient prospective payment system (PPS) claims were significant in all 4 years (fiscal year 1996—39 percent of the total \$8.5 billion; fiscal year 1997—31 percent of the total \$7.5 billion; fiscal year 1998—40 percent of the total \$7 billion; and fiscal year 1999—45 percent of the total \$4.4 billion). For example:

- A PPS hospital was paid \$3,883 to treat an inpatient with an episode of hypoglycemia. According to medical reviewers, the patient's condition and the treatment given did not require admission to the acute level of care, and the patient could have been safely evaluated and treated at a less acute level. Therefore, the entire payment was denied as medically unnecessary.
- Another PPS hospital was paid \$7,642 to treat an inpatient for dehydration. The beneficiary, who was initially treated in the emergency room, was eventually admitted to the hospital's acute care unit. The beneficiary received x-rays, blood tests, IV fluids, Tylenol, and a fever work-up but was discharged the same day. Medical reviewers concluded that the patient's condition did not require acute hospital inpatient care and that the services could have been rendered in an outpatient setting. Therefore, the entire payment was denied.

Incorrect coding

The medical industry uses a standard coding system to bill Medicare for services provided. For most of the coding errors found, medical reviewers determined that the documentation submitted by providers supported a lower reimbursement code. However, we did find a few instances of downcoding which we offset against identified upcoding situations.

Incorrect coding was the third highest error category this year, with \$2.1 billion in improper payments. Physician and inpatient PPS claims accounted for 90 percent of the coding errors over the 4 years reviewed.

Examples of incorrect coding follow:

- A PPS hospital was paid \$9,387 for an inpatient respiratory system surgical procedure. The medical records, however, supported a nonsurgical procedure. Medical reviewers' correction of the procedure code produced a lesser valued diagnosis-related group of \$2,481, resulting in denial of \$6,905 of the payment.
- A physician was paid \$50 for a psychotherapy session which requires medical evaluation and management. According to medical review staff, the physician's records evidenced neither the time spent nor the psychotherapy services performed. However, the records supported psychiatric medication management services in an office setting, for which a lower level of service would have been appropriate. Therefore, \$31 of the payment was denied.

Noncovered services

Errors due to noncovered services consistently constituted the smallest error category. Noncovered services are defined as those that Medicare will not reimburse because the services do not meet Medicare reimbursement rules and regulations. For example:

- A physician was paid \$30 for nail debridement. Medicare covers this procedure if there is evidence of diabetes in the beneficiary's medical history. However, there was no indication of diabetes in this beneficiary's history. Therefore, the service was considered routine foot care, which Medicare does not cover, and payment was denied.
- A hospital was paid \$21 for medications to an outpatient that medical reviewers determined could have been self-administered. Medications furnished in an outpatient setting are covered only if they are of a type that cannot be self-administered. As a result, medical reviewers denied the payment.

FINANCIAL STATEMENT AUDIT

Audit opinion

For fiscal year 1999, we are very pleased to issue the first unqualified, or "clean," audit opinion on HCFA's financial statements. In achieving this important milestone in financial accountability, HCFA has successfully resolved billions of dollars in past problems that formed the basis of our audit opinion for 3 years. Deficiencies in reporting and supporting Medicare accounts receivable, in particular, have been systemic and longstanding.

Medicare accounts receivable are debts that providers and other entities owe to HCFA. More than 50 Medicare contractors are responsible for tracking and collecting most of this debt through their claim processing systems. However, as we previously reported, their claim processing systems lacked general ledger capabilities and traditional accounting system features, such as a dual-entry process. In addition, the contractors used ad hoc spreadsheet applications to tabulate, summarize, and report information to HCFA. This reporting process was labor intensive, requiring significant manual input and reconciliations between various systems and spreadsheets. Previous audits found millions of dollars in discrepancies as a result; that is, the Medicare contractors were unable to support beginning balances, reported incorrect activity, and could not reconcile ending with subsidiary records.

This year HCFA embarked on an extensive effort to validate and document receivables. The project, which was jointly conducted by HCFA, my office, and two independent accounting firms, covered accounts receivable at 15 Medicare contractors (accounting for over 80 percent of the contractor receivable balance) and at the HCFA central and regional offices. The validation team identified over \$2 billion in overstated and understated receivables:

- \$1.3 billion lacked supporting documentation,
- \$1 billion concerned cash advances to providers for which claims had already been submitted, and
- \$191 million in misstatements resulted from clerical errors, e.g., a contractor erroneously recorded a \$50 receivable as \$70 million.

This validation effort, together with HCFA's aggressive action to require that contractors maintain support for this debt, enabled us to conclude that the receivables balance was fairly presented and sufficiently documented for the first time in 4 years.

Internal control weaknesses

While the receivables balance was supported at the end of fiscal year 1999, the underlying internal control environment and accounting systems still need substantial improvements, such as a basic double-entry bookkeeping system and adequate checks and balances to promptly detect errors and irregularities. These control weaknesses impair HCFA's ability to accumulate and analyze accounts receivable activity and to ensure that future receivables will be properly reflected in financial reports. These weaknesses also increase the risk that future debt may not be collected timely and that receivables may not be properly safeguarded. Compounding these problems, the HCFA central office does not routinely analyze receivable balances other than on a very aggregate level. Therefore, the fiscal year 1999 report on internal controls again includes Medicare accounts receivable as a material weakness. Material weaknesses are defined as serious deficiencies in internal controls that can lead to material misstatements of amounts reported in subsequent financial statements unless corrective actions are taken. To ensure that future accounts receivable activity and balances are fairly stated, HCFA will need to continue a very aggressive validation effort.

The other material weaknesses noted last year also carried over:

—*Financial systems and reporting.*—Controls over financial systems and reporting remain serious concerns. The HCFA did not perform adequate analyses of accounts receivable, revenues, and expenditures to understand why fluctuations took place and to ensure that balances were correct. For example:

The HCFA did not independently verify the Medicare Supplementary Medical Insurance (SMI) and Hospital Insurance (HI) trust fund balances, did not reconcile these accounts at a sufficiently detailed level, and used ineffective methodologies to calculate SMI and HI transfers. As a result, the SMI fund was underfunded by \$18 billion and HI was overfunded by \$14 billion. The SMI fund lost interest earnings of \$237 million and the HI fund realized excess interest earnings of \$154 million as a consequence. Although aggregate fund balances with Treasury and investment balances for the trust funds were properly stated in the fiscal year 1999 financial statements, cash transfers related to the principal to make the individual trust funds whole did not occur until October 1999.

The HCFA did not periodically validate the National Claims History File to ensure the existence and completeness of the data. Due to a breakdown in internal quality controls, the file was missing 100 million Medicare claims amounting to over \$13 billion from June until December 1999. This file, which has since been corrected, is critical to accurately estimate Medicare benefits payable, to prepare the Medicare trustees report, to determine the SMI monthly premiums, to establish managed care rates, to update the groups for inpatient hospitals, and to develop annual budget projections.

The HCFA had to make billions of dollars in manual adjustments to payables and receivables before producing final, auditable financial statements in late January 2000—4 months after the fiscal year ended. In addition, we noted that five of eight sampled Medicare contractors did not formally reconcile paid claims activity to monthly expenditures reported to HCFA. Without these reconciliations, the risk of material misstatement in the financial statements increases.

—*Medicare electronic data processing (EDP).*—Because HCFA's fiscal year 1999 resources were largely devoted to Year 2000 readiness issues, not all prior-year EDP control problems were resolved. Weaknesses remained in access controls at the HCFA central office and in application change controls at a "shared" system used by certain Medicare contractors to process and pay claims. Internal controls over Medicare systems are essential to ensure the integrity, confidentiality, and reliability of critical data while reducing the risk of errors, fraud, and other illegal acts.

Controls over cash management

In a matter related to our financial statement audit, we recently reviewed certain controls over cash management. The HCFA and the Medicare contractors have agreements with several banks to maintain

Medicare accounts to cover payments to providers. The HCFA expressed concerns about the way one bank handled Medicare funds related to eight fiscal intermediaries and one carrier. At HCFA's request, we reviewed the financial activities of the bank and the Medicare contractors. We noted that during an 11-day period, the bank withdrew funds from the Federal Reserve in excess of Medicare contractor expenditures. The excess ranged from \$104 million to over \$420 million per day and earned more than \$700,000 in interest.

In addition, since 1993, the bank has routinely withdrawn funds a day earlier than needed to cover Medicare expenses and has earned interest on those funds by investing them overnight. The bank estimated that the interest earned through these overnight investments totaled \$12.5 million. In 1999, HCFA advised the bank to stop this practice because it was contrary to the provisions of the agreement with HCFA and the Medicare contractors. Bank officials believed that withdrawing funds a day early was a "perk" of maintaining Medicare accounts and that bank charges alone were not sufficient to cover administrative expenses for the accounts.

Each of the Medicare contractors has a monthly limit on the total amount of Medicare funds that can be drawn down by the bank, and HCFA and its contractors have various reconciliation procedures to compare bank cash draws to expenditures and to Federal Reserve Bank reports. However, these controls were ineffective in preventing both types of improper withdrawals made by the bank.

CONCLUSIONS AND RECOMMENDATIONS

We are encouraged by HCFA's sustained success in reducing Medicare payment errors and by the important progress made in resolving prior years' financial reporting problems. We remain concerned, however, that inadequate internal controls over

accounts receivable leave the Medicare program vulnerable to potential loss or misstatement. As HCFA begins a lengthy process to integrate its accounting system with the Medicare contractor systems, internal controls must be strengthened to ensure that debt is accurately recorded, an adequate debt collection process is in place, and information is properly reflected on the financial statements.

We offered a number of recommendations which, if implemented, will strengthen controls over receivables and financial reporting. With the Year 2000 remediation challenge successfully completed, we urge HCFA to focus on these critical internal controls while continuing its efforts to reduce improper payments and ensure provider integrity. Specifically, we recommended that HCFA:

- Establish an integrated financial management system at the contractors to promote consistency and reliability in recording and reporting accounts receivable information.
- Establish a formal review process over accounts receivable to detect unusual fluctuations, anomalies, and unexpected variances.
- Ensure that contractors develop control procedures to provide independent checks of the validity, accuracy, and completeness of receivable amounts reported to HCFA.
- Develop an independent internal oversight group or internal audit function to monitor the contractors' compliance with HCFA reporting requirements for accounts receivable and verify the accuracy and completeness of information reported to the HCFA central office.
- Establish procedures for contractors to periodically reconcile accounts receivable balances to supporting documentation.
- Periodically review contractors' control procedures over the accounts receivable reconciliation process.
- Consider establishing a weekly limit on the total amount of Medicare funds that can be drawn by contractor banks.
- Require the HCFA regional offices to periodically test bank withdrawals to ensure there are no early withdrawals.

I appreciate the opportunity to appear before you today and to share our reports with you, and I will be happy to answer any questions you may have.

**STATEMENT OF HON. LESLIE G. ARONOVITZ, ASSOCIATE DIRECTOR,
HEALTH FINANCING AND PUBLIC HEALTH ISSUES, GENERAL ACCOUNTING OFFICE**

Senator SPECTER. Representing the General Accounting Office is Ms. Leslie Aronovitz, who has been at GAO since 1974.

She is Associate Director there for Health Financing and Public Health, and her responsibilities include the Department of Justice's use of false claims in health care matters and oversight of Medicare claims; an MBA from Boston University; a CPA.

Thank you for joining us, and we look forward to your testimony.

Ms. ARONOVITZ. You are very welcome. Thank you, Mr. Chairman, Senator Harkin, and Senator Craig. I am very pleased to be here today as you discuss Medicare Program integrity issues.

You have heard from the Inspector General Gibbs Brown and the HCFA Administrator, Ms. DeParle, about their efforts to quantify improper payments in the Medicare Program. We believe these efforts are very worthwhile. However, the Medicare error rate only provides a partial picture of Medicare Program vulnerabilities.

My remarks today will focus on the major challenges that HCFA still faces in safeguarding Medicare payments.

We believe that major information gaps exist in the Medicare Program. For example, in traditional fee-for-service Medicare, HCFA does not have a clear picture of the individual or relative performance of the private companies that it contracts with to review and pay providers' claims.

Although these companies are responsible for administering the lion's share of the program, that's the fee-for-service program, which is over \$170 billion in fiscal year 1999, HCFA does not have

a good enough handle on how well these contractors are performing their payment safeguard activities.

Agency evaluations of contractor performance have fallen short of the necessary rigor to provide meaningful management information. At the same time, until very recently, the agency's field and central offices had not been structured in a way that provided adequate program accountability.

HCFA, to its credit, has taken a number of promising steps to address these weaknesses. And we will be very interested in the agency's activities in the coming months.

Another information gap has to do with having the right data to monitor prospective payment systems effectively. The move from retrospective to prospective payments occurred after rapid—years of rapid spending growth for post-acute care services.

Prospective rates based on units of services—units of service, rather than cost, are expected to reduce a provider's incentive to deliver excessive services or incur unnecessary costs. However, no payment system or methodology is perfect or impervious to gaming.

Under the new approach, providers can inappropriately boost revenues by skimping on services. The secret to making prospective payment systems work as intended is to determine what level of service is appropriate for a beneficiary and to carefully monitor what level of services patients actually receive.

This is no easy task. It requires data on utilization and information systems that make the data readily available for analysis. To date, HCFA's information on patients' utilization of services is not sufficient.

The very same information gaps beset HCFA's efforts to monitor Medicare+Choice program payments, which are also made prospectively.

In fiscal year 1999, Medicare's payments to these plans totaled more than 17 percent of all program spending. And this share is expected to grow over time.

In recent years, we have reported on several problems. First, plans could purposefully seek to attract and retain only those beneficiaries who are relatively healthy and, therefore, low-cost.

Second, plans could fail to deliver required services to beneficiaries. Third, since payment rates are based in part on plan provided information, erroneous or misrepresented data—misreported data could lead to inappropriate payments.

Previous work by us and the Inspector General has uncovered instances in which plans received inappropriate payments or did not deliver services that they were paid to deliver.

Reliable information about plan enrollees will become even more critical in the future, as Medicare phases in a new method to adjust for patients' health status.

HCFA's information needs cannot be met with its existing automated systems. Owing to a failed attempt at modernization in the 1990s, HCFA's current systems remain seriously outmoded. At the same time, HCFA has been left with fewer and fewer administrative dollars to handle increasingly complex tasks. In 1998, HCFA's administrative expenses represented less than two percent of its outlays.

Even after accounting for marketing costs and profit, no private health insurer would attempt to manage such a large and complex program with so small an administrative budget. Nevertheless, providing more money alone would be imprudent without an effective strategic plan. Such a plan would specify how to transform the data collected into useful management information.

And we are aware that HCFA has started down this path, developing an IT architecture and—information technology architecture, and we will be interested in its evolving planning efforts.

This concludes my statement. And I will be more than glad to answer any questions you may have.

Senator SPECTER. I thank you very much, Ms. Aronovitz.

[The statement follows:]

PREPARED STATEMENT OF HON. LESLIE G. ARONOVITZ

Mr. Chairman and Members of the Subcommittee: I am pleased to be here today as you discuss Medicare program integrity issues. You have heard from the Department of Health and Human Services Office of the Inspector General (HHS OIG) and the Health Care Financing Administration (HCFA) about their efforts to quantify improper payments in the Medicare program. Specifically, the OIG has reported a fee-for-service claims error rate for the past several years and HCFA is planning to estimate an error rate for each claims administration contractor, which could help guide efforts to reduce inappropriate payments. Although we believe these efforts are worthwhile, Medicare error rates provide only a partial picture of program vulnerabilities. My remarks today will focus on areas of vulnerability, highlighting the ongoing and emerging challenges HCFA faces in safeguarding Medicare payments.

In summary, major information gaps exist in the Medicare program—in both traditional Medicare and Medicare+Choice—that impede HCFA's ability to minimize program losses attributable to improper payments. In traditional Medicare, HCFA does not have a clear picture of the individual or relative performance of Medicare's claims administration contractors, which are responsible for safeguarding the program's fee-for-service payments that totaled \$171 billion in fiscal year 1999. HCFA also lacks sufficient information on newly designed payment systems to determine whether providers have delivered excessive services or stinted on patient care to inappropriately maximize payments. As for Medicare+Choice, HCFA similarly lacks the data needed to monitor the appropriateness of payments made to health plans and the services Medicare enrollees receive. Owing to a failed attempt in the 1990s to modernize Medicare's multiple information systems, HCFA's current systems remain seriously outmoded. Without effective systems, the agency is not well-positioned to collect and analyze data regarding beneficiaries' use of services—information that is essential to managing the program effectively and safeguarding program payments.

IN TRADITIONAL MEDICARE, CLAIMS OVERSIGHT PROBLEMS REMAIN AND IMPROVED PAYMENT METHODS CAN STILL BE GAMED

In traditional Medicare, HCFA contracts with private companies, mostly insurance companies, to review and pay providers' claims for health care delivered to program beneficiaries. How well these companies have monitored Medicare's payments and have themselves been monitored by HCFA are the subjects of recent GAO reports. We have also reported on new prospective payment methods designed to replace outmoded cost-based reimbursement methods. Both contractors' payment safeguard activities and new prospective payment systems contain existing or new opportunities for unscrupulous providers to exploit Medicare.

Better vigilance needed over medicare contractors

In recent years, incidents have occurred in which Medicare's contract bill-payers themselves—the front-line of defense against provider fraud and abuse and erroneous Medicare payments—had engaged in fraudulent or otherwise improper activities. However, HCFA rarely uncovered these cases through its own oversight efforts. The reason, in part, is that the agency relied on contractors' self-certifications of management controls and contractors' self-reported data on performance and seldom made independent validations of contractor-provided information. In a number of

the contractor integrity cases, poor management controls and falsified data were recurring themes.

Not surprisingly, our report last year on HCFA's efforts to monitor the Medicare claims administration contractors identified many weaknesses.¹ For years, HCFA's contractor evaluation process lacked the consistency that agency reviewers needed to make comparable assessments of contractor performance. HCFA reviewers had few measurable performance standards and little agency wide direction on monitoring contractor's payment safeguard activities. Under these circumstances, the reviewers in HCFA's 10 regional offices, who were responsible for conducting contractor evaluations, had broad discretion to decide what and how much to review as well as what disciplinary actions to take against contractors with performance problems. This highly discretionary evaluation process allowed key program safeguards to go unchecked and led to an inconsistent treatment of contractors with similar performance problems.

In addition to having a weak evaluation process, HCFA had not made its multiple units that were responsible for contractor oversight adequately accountable. Responsibility for various aspects of contractor activities was splintered across many central office components, while regional staff who conducted day-to-day oversight were not directly accountable to any particular central office unit. HCFA has taken a number of promising steps to address these weaknesses and to achieve the following goals:

- Greater consistency.*—HCFA has begun using national review teams to conduct contractor evaluations. The teams combine the expertise and dual perspective of central and regional office staff.
- Improved accountability.*—HCFA established an executive-level position at its central office with ultimate responsibility for contractor oversight and recently announced plans for four positions in the field, reflecting the four groupings of regional offices known as consortia. The four consortium representatives responsible for contractor oversight will report both to the central office executive and to their respective consortium administrators.
- Independent verification.*—To address the need for independent verification of internal controls and contractor-reported data, HCFA hired a public accounting firm to develop standard review procedures and evaluation methodologies.
- More meaningful error rates.*—HCFA has an initiative, as you have heard today, to develop a separate error rate for each contractor. It plans to hire a "validation" contractor to randomly sample processed claims and recheck the processing and payment decisions made. From the results, HCFA could not only develop an objective measure of contractor performance but also identify which categories of services or provider types are the source of improper billing practices, thus targeting areas that need improvement.

Because these steps were taken recently, we have not evaluated their success in addressing the agency's long-standing, fundamental problems in overseeing its contractors.

Opportunities to game new payment methods difficult to control without adequate management information

To constrain Medicare spending on unnecessary services, the Balanced Budget Act of 1997 (BBA) introduced several payment reforms. The BBA called for HCFA to develop and implement new methods to pay for post-acute care—that is, the care Medicare beneficiaries receive principally from skilled nursing facilities, home health agencies, and rehabilitation facilities. Under cost-based reimbursement methods used to pay post-acute care providers, Medicare experienced rapid growth in post-acute care spending during the 1990s. At the same time, program funding decreased for such safeguard activities as auditing providers' cost reports.

Under the old payment methods, post-acute care providers were reimbursed their costs (within certain limits) for all the services delivered. Under the new methods, known as prospective payment, these providers are, or soon will be, paid a prospective rate per unit of care. The expectation is that prospective payment systems will encourage the efficient delivery of care by reducing a provider's incentive to deliver excessive services or incur unnecessary costs. Providers face the risk of loss if their costs exceed their payments, while those that can furnish care for less than the prospective payment rate will retain the difference. However, a new opportunity for providers to inappropriately boost revenues exists under this approach: providers could skimp on services and compromise the patient's quality of care. Because HCFA does not have the analytic tools available to identify and document under

¹ See *Medicare Contractors: Despite Its Efforts, HCFA Cannot Ensure Their Effectiveness or Integrity* (GAO/HEHS-99-115, July 14, 1999).

service, any resulting improper payments would not be captured by error rates as currently constructed. In fiscal year 1999, Medicare's payments for skilled nursing facility and home health care together totaled \$28 billion.

Not all patients require the same amount of care, so the rate paid for each patient is "case-mix" adjusted to take into account the nature of the patient's condition and expected care needs.

These adjustments are required to ensure that providers serving patients with more intensive care needs receive adequate payments and, conversely, that providers are not overcompensated for patients with lower care needs. Used in conjunction with a prospective per-unit payment, case-mix adjustment is intended to reduce the incentive to inappropriately increase profits by furnishing more or fewer services than are needed. However, several analytical problems make ensuring the appropriate payment for each patient a thorny issue, as illustrated by the following types of post-acute care services.

- Skilled nursing facility care.*—Under the skilled nursing facility prospective payment system, facilities receive a payment for each day of a patient's care, adjusted for case mix. This approach was intended to control the rapid growth in certain skilled nursing facility care costs. As we reported last year,² however, the case-mix adjustment methodology is flawed. The case-mix groups that influence payment amounts for each patient are defined largely by service use rather than by actual patient need. Thus, a facility could increase a patient's reported service use merely to increase payments.
- Home health care.*—Under the home health prospective payment system to be implemented in October, Medicare will pay agencies a per-episode rate for up to 60 days of services for a patient. Payment will be the same regardless of the number of days of care or visits actually provided, and there are no limits on the number of episodes a beneficiary could have. This approach is intended to reward home health agencies for constraining service use within an episode by encouraging efficient service delivery. However, with no limits on the number of episodes provided, providers continue to have the opportunity to increase aggregate payments. In addition, defining an adequate level of services within an episode is a problem, given a lack of agreed-upon standards for the appropriate use of home health care. Further, HCFA does not have the monitoring capability to determine—in time to make a difference to the beneficiary—whether the services provided within an episode are too few to be considered adequate care.
- Inpatient rehabilitation therapy.*—The prospective payment system for rehabilitation facilities to be phased in beginning October 2000 is expected to be based on a single payment for all services provided during a stay, like the payment for acute-care hospitals. This approach is intended to reward providers that deliver care efficiently. However, it will be difficult to devise controls to keep facilities from merely discharging patients earlier. The shorter stays would reduce the facilities' costs but may not achieve the appropriate level of rehabilitation for the patient. Such an outcome could not only jeopardize the quality of a beneficiary's care but also raise costs for Medicare if more post-acute care is needed after discharge.

MEDICARE + CHOICE HAS ITS OWN SET OF INTEGRITY ISSUES

The claims error rate is also an incomplete measure of payment problems because it does not apply to dollars paid to health care plans that participate in the Medicare+Choice program. In fiscal year 1999, Medicare's payments to these plans totaled \$37 billion, or more than 17 percent of all program spending, and this percentage is expected to grow over time. Because a Medicare+Choice plan receives a fixed monthly payment for each beneficiary it enrolls, instead of being paid separately for each service delivered, this program raises a new set of program integrity challenges.

Broadly speaking, the following three situations illustrate the program integrity issues that potentially exist in Medicare+Choice. First, plans could purposely seek to attract and retain only those beneficiaries who are relatively healthy and low-cost. Second, plans could fail to deliver required services to beneficiaries. Finally, since payment rates are based in part on plan-provided information, erroneous or misreported data could lead to inappropriate payments. Previous work by us and the HHS OIG has uncovered instances in which plans received inappropriate payments or did not deliver services that they were paid to deliver. Although the full

²*Medicare Post-Acute Care: Better Information Needed Before Modifying BBA Reforms* (GAO/T-HEHS-99-192).

extent of these problems is not known, the available information suggests that HCFA needs to improve its capacity to monitor plan performance and ensure that payments are appropriate and that plans fulfill their obligations. The following elaborates on the program integrity challenges in Medicare + Choice.

- Favorable selection of healthier beneficiaries.*—Plans gain financially when their enrolled Medicare beneficiaries are, as a group, healthier than beneficiaries in traditional Medicare—a phenomenon known as favorable selection. This gain occurs because healthy beneficiaries cost less to serve than chronically or acutely sick beneficiaries and Medicare's payment is not adequately "risk adjusted" to reflect that fact. Our recent work examining those who join Medicare + Choice plans confirms varying degrees of favorable selection among the health plans. This enrollment pattern could have a benign explanation: healthy beneficiaries may be more willing to enroll than sick beneficiaries, who could have attachments to providers that might not belong to the selected plan's provider network. However, it is also possible that some plans—through their marketing practices or provider incentive arrangements—attract healthier beneficiaries and have more of their sick members disenroll. Regardless of the cause, the consequences of favorable selection in the presence of an inadequate risk adjuster are huge—resulting in billions of dollars in excess payments.³
- Failure to deliver required services.*—Plans could also profit by not providing services that they are paid to deliver. Last year we reported that a large Medicare + Choice plan provided a prescription drug benefit with less coverage than it agreed to in its contract with HCFA.⁴ This case was discovered in our review of plan marketing materials, which found that several plans distributed misleading, inaccurate, or incomplete information about covered benefits. Until recently, when plans started submitting data on hospital admissions, HCFA had no systematic information regarding the services managed care enrollees received. Instead, the agency relied, and to a great extent continues to rely, on beneficiaries being aware of the services to which they are entitled and complaining when those services are not provided. This weak oversight mechanism cannot ensure program integrity. Medicare is a complex program, and many beneficiaries do not understand what benefits the program covers. Flawed plan marketing materials contribute to the misunderstandings. In addition, beneficiaries may not know where or how to complain. We reported last year that several plans failed to adequately inform beneficiaries that they could appeal a plan's decision to deny services or payment for services.⁵
- Misreported or erroneous data that increase payments.*—A final area of potential concern relates to the data used for payment purposes. For example, in 1998 we reported that some plans took advantage of an overly broad Medicare definition to classify healthy beneficiaries living in retirement communities as living in "institutions" and thereby substantially increase their Medicare payments.⁶ HCFA has since adopted our recommendation to tighten the definition of an institution for payment purposes, but the extent to which the new definition is being enforced is uncertain. The OIG has reported numerous instances in which erroneous data resulted in inappropriate plan payments. For example, the OIG found cases in which Medicare paid plans for deceased beneficiaries and for beneficiaries receiving services in traditional Medicare. The OIG also found plans that inappropriately collected enhanced payments by misreporting their beneficiaries' institutional status. Reliable information about plan enrollees will become even more critical in the future as Medicare phases in a new risk adjustment methodology. Under this new methodology, payment rates will be determined largely by provider encounter data submitted by plans. Any errors in the encounter data will thus result in inaccurate plan payments.

OUTDATED INFORMATION SYSTEMS LIMIT HCFA'S ABILITY TO MANAGE MEDICARE

A major structural issue underlies HCFA's efforts to safeguard Medicare payments: the need for reliable management information. This is true whether the information pertains to payment of claims, new post-acute care payment methods, or Medicare + Choice payments. To protect taxpayer dollars from unnecessary program

³Medicare HMOs: HCFA Can Promptly Eliminate Hundreds of Millions in Excess Payments (GAO/HEHS-97-16, Apr. 25, 1997).

⁴Medicare + Choice: New Standards Could Improve Accuracy and Usefulness of Plan Literature (GAO/HEHS-99-92, Apr. 12, 1999).

⁵Medicare Manage Care: Greater Oversight Needed to Protect Beneficiary Rights (GAO/HHEHS-99-68, Apr. 12, 1999).

⁶Medicare HMO Institutional Payments: Improved HCFA Oversight, More Recent Cost Data could Reduce Overpayments (GAO/HEHS-98-153, Sept. 9, 1998).

spending, HCFA needs the information to ensure that claims payments are accurate and that payment rates are set at the appropriate level. To protect beneficiaries from providers' withholding needed services, HCFA needs information on beneficiaries' health status and use of services. The following are among HCFA's major information challenges:

- Traditional Medicare.*—In addition to a long-standing need to upgrade its claims analysis capabilities, HCFA requires information on patient health needs. As discussed earlier, major gaps in information make prospective payment systems vulnerable to manipulation, thus undermining the potential for the prospective payment approach to constrain Medicare costs. For example, payments for skilled nursing facility and home health care would be more accurate if linked to patient need rather than to service use, but HCFA has only begun collecting the data necessary to develop standards of appropriate care.
- Medicare + Choice.*—As with the case-mix adjuster for post-acute care payment methods, Medicare needs an improved risk adjustment system to ensure that payments better reflect the expected health care costs of managed care enrollees. Recently, HCFA launched several initiatives, including a beneficiary satisfaction survey, the collection of selected self-reported plan performance measures, and the collection of hospital admissions data to improve Medicare's risk adjustment methodology. Collection of more comprehensive encounter data is planned for the future. However, HCFA lacks a coordinated strategy to analyze these data and use the results to improve its oversight responsibilities.

HCFA's information needs are not being met with Medicare's existing fragmented and aged set of computerized information systems. Seriously affected are the systems that support traditional Medicare, Medicare + Choice, and HCFA's financial management efforts.

In the early 1990s, HCFA launched a systems acquisition initiative to replace Medicare's multiple, contractor-operated claims processing systems with a single and more technologically advanced system, called the Medicare Transaction System (MTS). HCFA envisioned that a modernized, single system would (1) save administrative dollars and simplify making system changes, (2) enhance HCFA's ability to manage the Medicare contractors by obtaining uniformly formatted, comparable data, and (3) greatly improve the ability to spot, both on-line and after payment, improper billing practices. Although MTS was based on the sound notion that a comprehensive, integrated system was needed, it failed operationally, through a series of planning and implementation missteps. HCFA's failure to acquire an integrated system left the program with numerous aging information systems that needed year 2000 renovation.

Similarly, HCFA's managed care information systems, developed a decade ago, may have reached their capacity to accommodate modifications associated with an increasingly complex and demanding program. An outside firm's assessment of HCFA's managed care information capacity found, among other problems, that the current system makes it difficult to extract information for policy decisions and program management; is labor-intensive to modify and validate; and, because of its batch processing structure, does not provide timely information on beneficiary enrollment or other plan transactions.

Finally, with regard to financial management, HCFA cannot ensure that key financial data are reliable and available or that sensitive beneficiary data are kept confidential. In repeated annual audits, the OIG found that HCFA's and the contractors' systems can be penetrated, leaving sensitive claims and medical record information inadequately protected. The focus on year 2000 system renovations has, in part, delayed HCFA's efforts to address the security weaknesses identified. HCFA also lacks an integrated accounting system to examine Medicare expenditures at the contractor level, depending instead on labor-intensive processes to prepare financial statements. HCFA has an initiative under way to develop an integrated accounting system, but it will not be fully operational until 2004 at the earliest.

While it is clear from the problems outlined that investment in HCFA's information systems is warranted, such an investment must be coupled with a clear strategy to ensure that investment is made wisely. In efforts to run the program economically, HCFA has been left with fewer and fewer administrative dollars to handle increasingly complex tasks. In 1998, HCFA's administrative expenses represented about 1 percent of its outlays from the Hospital Insurance Trust Fund and about 2 percent of outlays from the Supplementary Medical Insurance fund. Even after accounting for marketing costs and profit, no private health insurer would attempt to manage such a large and complex program with so small an administrative budget. HCFA's ability to provide assistance to beneficiaries, monitor the quality of provider services, and protect against fraud and abuse is dependent on adequate administrative funding. Nevertheless, providing increased funds for upgrading systems

would be imprudent without an effective strategic plan. Such a plan would, among other things, envision how to transform the data collected into useful management information. We are aware that HCFA has started down this path, and we will be interested in its evolving planning efforts.

CONCLUSIONS

Despite BBA reforms and HCFA's many important initiatives, Medicare remains a high-risk program. Its coverage policies and payment systems, affecting almost 40 million beneficiaries and hundreds of thousands of providers, are highly complex and susceptible to exploitation. HCFA's most significant tools for combating the problem of improper payments are the systems that produce information about beneficiaries' use of services. Over the last 2 years, HCFA's information technology efforts focused largely on preparing Medicare's systems to meet year 2000 readiness requirements. The time lost while HCFA was focused on other priorities makes modernizing Medicare's multiple information systems now all the more compelling.

Mr. Chairman, this concludes my prepared statement. I would be happy to answer any questions you or other Subcommittee Members may have.

Senator SPECTER. Taking up the issue, first, of the regulatory system and some of the complaints of the American Medical Association, Ms. DeParle, I think they do raise an issue, which requires some consideration when they complain about the failure of HCFA or the absence of an 800 number for physicians to call in with complaints. Have—has HCFA considered having an 800 number?

Ms. DEPARLE. Not only has HCFA considered it, but we are doing it.

Senator SPECTER. Oh, you are going to do it?

Ms. DEPARLE. We are going to do it. It costs money, but we are going to take, the estimate is around \$4 million to supply an 800 number that providers, especially physicians who have raised this, can call in and get their questions answered.

Senator SPECTER. When do you expect to have that operative?

Ms. DEPARLE. I need to get back to you, Senator. I would hope by this summer, but I do not want to give you a date unless I am sure of it.

Senator SPECTER. With respect to the complications of the regulatory system generally, Ms. Brown, as you state some of the critical failings, like not having any backup materials to identify or justify the procedure, to what extent is AMA justified in complaining about the complex regulations when you come to matters of overbilling and matters which are fraudulent, Ms. Brown?

Ms. BROWN. Well, I think they are very nervous and probably very sincere, but I am sure that you could look through our records and find that there have been no prosecutions of people who have made inadvertent errors or misjudgment of one or two levels in a coding or—

Senator SPECTER. Well, aside from the prosecution issue, what justification do they have, if any, for complaining that the regulations are too complicated, to be able to give guidance on the items that you have reported as erroneous or fraudulent?

Ms. BROWN. Certainly, there is no doubt that the Medicare regulations are complicated. And I think that HCFA has made great strides and is continuing to try and simplify those regulations, also providing educational opportunities through the contractors to contact the various provider groups and give them explanations. We are doing a lot of that work, too. We give advisory opinions, and we provide voluntary—

Senator SPECTER. Are the regulations too complicated for them to understand on the items you have identified in your audits?

Ms. BROWN. I do not believe they are. I think they—

Senator SPECTER. Ms. DeParle, how about the broader question of simplification of regulations? Congress has stepped in in a pretty firm manner on IRS. Should we be doing that with HCFA?

Ms. DEPARLE. Well, I have done so, sir. I have established a physician regulatory—

Senator SPECTER. To what extent have you simplified your regulations?

Ms. DEPARLE. We have done as much as we can. We stopped something that the AMA said they did not like, which was a documentation guideline system that—before I got there, HCFA had worked for several years with the AMA to establish this new documentation system. They decided they did not like it, that it was too complicated, or a number of their members did.

So we stopped it. We went back to the drawing board. We have been working with them on another system. We intend to test it this year.

We have gone all over the country meeting with physicians, asking them to let us know about things that we can make simpler. But I have to tell you, you know, we have a common interest with the physician community, as I know you do, in making sure that Medicare is fiscally sound.

And a lot of the things that the Inspector General has identified in these audits are not things where regulation had anything to do with it.

It is: "Did you see the patient, or did you not? Did you perform the service, or did you not?" Those are not things that you need a regulation—

Senator SPECTER. Regulations do not affect that, do they?

Ms. DEPARLE. Right.

Senator SPECTER. Ms. Aronovitz, your work with GAO comprehends the Department of Justice's use of false claims. To what extent are there criminal prosecutions for these matters?

You cannot be convicted of fraud for a complex regulation. A fraud conviction requires intent, an intent to defraud, which is an intent to cheat—

Ms. ARONOVITZ. Yes.

Senator SPECTER [continuing]. An intent to obtain money where it is not justifiably due.

Ms. ARONOVITZ. Right.

Senator SPECTER. To what extent, does the Department of Justice now use the criminal process, and to what extent in your view should the criminal process be used as a deterrent?

Ms. ARONOVITZ. Well, I think the criminal process is a very important part of the whole—the whole compliance process, but it is only one part. It is way at the end. And there are very few people who are actually subject to that part of the process.

We need to make sure that, up front, people understand the regulations. They follow them, and that there is immediate information that HCFA has that could either stop a payment before it gets paid, or immediately try to recover money.

Senator SPECTER. Come back to my question.

Ms. ARONOVITZ. Right. The—

Senator SPECTER. How frequently does the Department of Justice—

Ms. ARONOVITZ. Yes.

Senator SPECTER [continuing]. Institute criminal prosecutions in this area?

Ms. ARONOVITZ. Since the Health Insurance Affordability and Accountability Act gave the Department of Justice and the I.G. and HCFA more money to use the false claims, they are doing, I think, a much better job in prosecuting health cases. But they really do have a standard that they have to apply in the false claim to—

Senator SPECTER. Give us an idea as to what extent they are using the criminal process. Give us a number, a quantification. To what extent do they bring criminal charges?

Ms. ARONOVITZ. I really would need to find out specifically.

Senator SPECTER. Would you provide the subcommittee with that?

Ms. ARONOVITZ. Sure. Sure.

Senator SPECTER. And the other part of the question, which you have not addressed is: To what extent ought there to be more criminal prosecutions?

Ms. ARONOVITZ. Well, I think that there should be criminal prosecutions wherever it is warranted. And the question is how you identify the cases that are worthy of prosecution. And that is the challenge that the Department of Justice and the I.G. and HCFA has, and that is one that is going to continue.

Senator SPECTER. I would appreciate it if you would focus on the question a little more.

Ms. ARONOVITZ. I would be happy to.

Senator SPECTER. Give us a better response on the extent that there are criminal prosecutions, an evaluation as to the deterrent effect of the criminal prosecutions, and areas where your judgment is there ought to be more or less criminal prosecutions.

Ms. ARONOVITZ. OK. We will be happy to do that.

Senator SPECTER. Senator Harkin.

Senator HARKIN. Thank you, Mr. Chairman. I am going to pick up on that a little bit, because criminal prosecution is one thing, but making sure that if people make a mistake once or twice and they are not allowed back in the system for awhile, may be even more of a deterrent than criminal prosecutions.

I just want to ask, first, Ms. Gibbs-Brown, why the two previous audits again showed steady progress, then came back up? And, again, for the record, to what do you attribute this? Why do we have this little setback? To what do you attribute this, the fact that we were coming down and now we have gone back up again, especially in unsupported service?

Ms. BROWN. Sir, I do not believe that it is statistically significant, because as I mentioned there is a range in there, and so it was so much within that range that it is probably a plateau.

You know, in the first year where it came down to \$21-plus billion, we were concerned as to whether that was really the start of a trend or whether or not that was a fluctuation because of the statistical sampling technique.

Senator HARKIN. OK.

Ms. BROWN. We found that it not only was the start of a trend, but a very quick incline. And I think that we have really resolved a lot of the easier problems. And now we are at the point where it is going to take some intensive work.

And I do think that HCFA has taken some very aggressive action that should get this decline in erroneous payments down even further.

Senator HARKIN. You are just saying that we got the easy stuff first. Now, it is getting harder?

Ms. BROWN. That is right.

Senator HARKIN. Does the figure of total mispayments, the whole thing, \$13.5 million, include all of the losses to the program from fraud, waste and abuse, or are there additional losses, such as those to excessive payments for medical supplies, what I was just pointing out there? It does not include this, does it?

Ms. BROWN. No, not at all.

Senator HARKIN. It does not. Do you have any idea of what we are talking about here?

Ms. BROWN. This is strictly overpayments in the fee-for-service area.

Senator HARKIN. All right.

Ms. BROWN. A percentage is probably fraud. We have forwarded some of these cases to our investigative unit to look into further.

Senator HARKIN. Yes.

Ms. BROWN. But there is many types of fraud. It would not even start to identify—

Senator HARKIN. Well, I do not think this—this is not fraud.

Ms. BROWN. This waste—no, no.

Senator HARKIN. That is not fraud.

Ms. BROWN. Those are things allowed by the current system.

Senator HARKIN. Yes.

Ms. BROWN. And there needs to be changes, a lot of which were made under the Balanced Budget Act and—

Senator HARKIN. Do you—

Ms. BROWN [continuing]. Improvements are being made, but too slowly.

Senator HARKIN. Well, and I just—you know, again, I want, Mr. Chairman, for the record to show that this does not include—

Ms. BROWN. Yes.

Senator HARKIN [continuing]. All of the overpayments that are going out.

Ms. BROWN. That is true.

Senator HARKIN. And do you—can you extrapolate for us what—or have you looked at how much more might be going out if you extrapolate on medical devices, for example, and—or supplies, medical supplies?

Ms. BROWN. The sampling technique does not allow us to actually do it with this technique.

If I could mention just a couple of other things that might also have the chairman's question answered a little bit better: For instance, in the last 2 years since more funding was provided, a great deal of it through your efforts, sir, why, the results in 1997 through 1999 include we won and negotiated over \$2.2 billion in judgment settlements and administrative positions in fraud cases.

Senator HARKIN. How much? \$2.2 billion?

Ms. BROWN. \$2.2 billion in fraud cases. \$1.6 billion of that has been put back in the trust fund. Some—

Senator HARKIN. OK. Can I interrupt you? That leads me to my next question, and that was the—I have been arguing for years that we need more in the—what is that account called?

Ms. DEPARLE. Medicare Integrity Program.

Senator HARKIN. Thank you. So what is the return on that now? Remember, we were always talking in the past about the return per person we had. I think it was like 13 to 1 at one time, if I am not mistaken.

Ms. BROWN. Yes. OK. In the last 2 years, we have—from our office's efforts, of course combined with other people such as the Department of Justice that prosecutes, and HCFA who helps, but we have—in 1998, we had a \$99 to \$1 return. In 1999, a \$98 to \$1 return. So—

Senator HARKIN. So for every dollar that we put in the Program Integrity account, and that includes the personnel obviously—

Ms. BROWN. Yes, absolutely.

Senator HARKIN [continuing]. And the accountants and whoever you have hired, for every dollar we put in that, we returned \$99 to the trust fund.

Ms. BROWN. Most of it goes into the trust fund. There is some awards for the KWETAM people and so on. Justice gets 3 percent. But the majority of it all goes back into the trust fund now.

Senator HARKIN. Would you supply for me again—maybe Peter or someone has it, and I just have not asked them this. But what has been the record in that account?

How many personnel—how many people do you have working there, and show me for the last several years?

Ms. BROWN. All right.

Senator HARKIN. I think it was low; then it came up. We hired some more in the last few years. But where are we now? And how much more—well, let me handle, "How much more?"

But, please, if you can get to me how many people, because obviously if we are getting \$99 return for every \$1 that we have invested, we have got a long way to go before we reach a break-even point.

Ms. BROWN. Yes. I should correct myself, in that some of that money was through system improvements, such as the things you held up, where it is legal to make certain charges but it is not common sense to do it.

And some of those things do not come back, but they are savings that will appear because of changes in regulations, in some cases in laws and so on.

That money that is a result of criminal prosecutions or settlements and other types of recoveries through audit and so on does go back into the trust fund. So the whole \$99 does not, but regardless of that, there is a tremendous return on investment.

Senator HARKIN. Well—

Ms. BROWN. And we can certainly use more money. We have not reached the level of diminishing return.

Senator HARKIN. Would you delineate that out for me a little bit better—

Ms. BROWN. Yes.

Senator HARKIN [continuing]. Not now today, but get it to me?

Ms. BROWN. Yes. I would be glad to.

Senator HARKIN. I mean, on how much really came back to the trust fund. If it is not \$99, it must be somewhere around—

Ms. BROWN. OK.

Senator HARKIN. I do not know what it is.

Ms. BROWN. All right. Per dollar spent?

Senator HARKIN. Yes. Exactly.

Ms. BROWN. Yes. Okay. I will do that.

Senator HARKIN. Thank you.

Senator SPECTER. Ms. Brown—thank you, Senator Harkin. On the issue of not identifying or establishing that a service was performed, that is a fairly clear-cut matter.

When you testify about unnecessary services, what is the judgment call there by the auditors, contrasted with the medical judgment as to what is a necessary service?

Ms. BROWN. The auditors actually do not make the judgment. We have medical people who do that review and if—Joe Vengrin, who conducted these audits, can probably give you a little better detail.

Mr. VENGRIN. Yes. Senator, on—

Senator SPECTER. I am asking you that question because we have that concern on the HMOs where there are disagreements as to whether, on the recommendation of a general practitioner for a specialist, the HMO declines really with the motivation to keep down costs.

Ms. BROWN. Yes.

Senator SPECTER. And the thrust of this question goes to whether you are second guessing the physicians and how that works out.

Mr. VENGRIN. Senator—

Senator SPECTER. Could you identify yourself for the record, please?

Mr. VENGRIN. Yes, sir. I am Joe Vengrin, Assistant Inspector General for audit.

In this case here, 92 percent of these errors were detected by the medical review. The other 8 percent were pricing errors and some duplicate payments that the auditors found, but the preponderance of these errors were found by the medical review.

And typically we use the physicians, the pros, or the contractors who process these claims, the medical review staff. And it goes through a multitude of levels of additional reviews. So in many cases, it is not just one medical professional; it is more than two or three in some cases.

Senator SPECTER. How do you come to the point on the judgment that it is an unnecessary service? Inspector General Brown testified on unnecessary services. How is a determination made disagreeing with the physician's judgment that it was necessary where the auditors or HCFA say it is unnecessary?

Mr. VENGRIN. It is the medical staff. And the medical staff when they see the medical records, they are saying, for example, that the inpatient services was not needed.

Either the beneficiary did not require the level of care, or the service could have been provided on an out-patient basis; or in the

cases of durable medical goods that the beneficiary did not need the particular service. It was unneeded.

Senator SPECTER. And to what extent, again, are the claims made on what you regard as unnecessary services?

Mr. VENGRIN. I am sorry, sir. I did not understand—

Senator SPECTER. To what extent is that a problem, arithmetically?

Mr. VENGRIN. The medical necessity is \$4.4 billion.

Senator SPECTER. What is your judgment, Ms. Brown, about the issue of deterrents? Information and education is a big factor. We were discussing that.

To what extent are these false claims deterrable, and how?

Ms. BROWN. I think we have already seen a big change, particularly in hospitals where they are billing correctly now after some aggressive action in getting money back when there was overbillings.

Even most experts who have analyzed the inflation rate of the payments out of Medicare have attributed the fraud and abuse efforts to a great degree for the diminishing amount of inflation that has occurred in the Medicare area.

So I do think that we are having a tremendous deterrent effect. And for the many, many—the vast majority of providers who are honest and trying to do a good job, it—they are doing a good job. But we have these outlying cases, which also have to be addressed.

Senator SPECTER. Ms. Brown, one question if I may: On a parochial subject, the fiscal year 2000 appropriation bill has a provision for an I.G. field office in Pittsburgh.

Ms. BROWN. Yes, sir.

Senator SPECTER. When may I visit there?

Ms. BROWN. We are working with GSA currently to get space, and I certainly expect it before the end of this fiscal year. We currently have 95 people in Pennsylvania. And there are three in Harrisburg.

Senator SPECTER. Well, that is more than I have in Pennsylvania, aside—

Ms. BROWN. Most of them are in Philadelphia.

Senator SPECTER [continuing]. Aside from my 12 million constituents.

Ms. BROWN. But we are opening the office in—

Senator SPECTER. So the end of the fiscal year, that is September 30 on my calendar.

Ms. BROWN. It will be opened before that. And I will invite you to the opening, sir.

Senator SPECTER. OK. Thank you very much.

As I said earlier, I am going to have to excuse myself, and I yield and leave the gavel in good hands with Senator Harkin—

Senator HARKIN. OK.

Senator SPECTER [continuing]. With the admonition that this does not reflect a change in party control.

Senator HARKIN [presiding]. All right. Thank you, Arlen. Thank you, Mr. Chairman.

And I just have a few more, then I have an elementary and secondary education markup that I have to go to also. But thank you, Mr. Chairman.

I just want to ask, Ms. Brown, one thing. Do you believe that taxpayers—it is just—I want to get this on record. Do you believe that taxpayers would see a positive return if Congress were to expand funding of the I.G. under the, I guess, it is called the health-care fraud and abuse account, which is the program integrity account?

I know you have already told me what the average return is. My question is: Would taxpayers see a positive return if Congress were to expand funding for the I.G. under this account?

Ms. BROWN. I can say absolutely, yes. I think that the point of diminishing return has not been reached. There are some large areas where we are not able to even provide coverage. We talked about the contractors. We have had 14 contractors now where we have had large settlements.

And I think it was mentioned in the opening, Connecticut General Life Insurance Company is paying back about \$9 million now for overcharging.

Senator HARKIN. Yes.

Ms. BROWN. The contractors also have as we have testified here in our financial statement audit, they are not doing any double entry accounting. They are not—they are being very careless. There often is not backup, any subsidiary account at all for accounts receivable.

Now, HCFA has cleaned this up. But there is really no excuse for saying you have all these receivables and not having anybody that is responsible for that. It is my belief that we ought to have auditors at the contractor level to do ongoing monitoring.

Senator HARKIN. Yes.

Ms. BROWN. I really got this idea when I was—or from my experience at Department of Defense. We are paying almost \$170 million—billion out at those contractors.

In Defense, they have DCAA, which is auditors who work at the various defense contractors level, and they monitor what is going on and keep things up to date.

Senator HARKIN. Are they under the I.G.'s jurisdiction?

Ms. BROWN. No. They are separate from the I.G., but, of course, that has been longstanding, long before the I.G. even appeared there.

Senator HARKIN. I see.

Ms. BROWN. I think there could be a separate division in the I.G. who did this contractor work and that you would see very, very impressive results as a result of that.

Senator HARKIN. Do you have any idea how many personnel we are talking about and how much it might cost?

Ms. BROWN. I—

Senator HARKIN. If you do not today, if you could send it—

Ms. BROWN. What we worked up when we were trying to develop this proposal, it would be about \$15 million for the I.G.

Now, there is also responsibility at HCFA, and they are putting substantial resources into that area in the near future. They have already developed their plans, and they do have some funding for it. But there is not funding that has been provided for the I.G. Office.

Senator HARKIN. Well, I am a little confused here. If you are going to have the auditors, as I understand, at the contractor level, would those contractors work for you, Ms. DeParle, or for Ms. Brown? I am a little confused.

Ms. BROWN. There—the contractors for HCFA—

Ms. DEPARLE. The contractors contract with Medicare, but then we have a job to do in overseeing them to make sure they are doing their basic responsibilities. We need to step up those efforts, as I think you can tell from this report today.

Senator HARKIN. Right.

Ms. DEPARLE. So that is what we are in the process of doing. But the Inspector General has an additional plan on top of that. And we are doing a lot of our work, frankly, sir, through contractors.

We have hired an independent accounting firm, because we have a very small staff, as you know, to go out to 25 of the 55 contractors and go through their books and go through their internal controls and just, you know, go through line by line.

What June is talking about is an effort where there would be an ongoing presence at the contractors—

Senator HARKIN. Right. I understand that.

Ms. DEPARLE [continuing]. And from the Inspector General's Office.

Senator HARKIN. Well, that auditor would be under the Inspector General's office—

Ms. DEPARLE. Yes, sir.

Senator HARKIN [continuing]. Not under your purview.

Ms. DEPARLE. Yes, sir.

Senator HARKIN. Again, so you are saying that to do that adequately, you would need \$15 million additional to hire—

Ms. BROWN. Yes. I think we could cover 80 percent of the contract dollars going out, with about that amount so—I had worked up a proposal. And it would come to about \$15 million, and we would have a separate division who took care of that.

Senator HARKIN. Did you submit that proposal to OMB and all that kind of stuff?

Ms. BROWN. It was not accepted by OPM—OMB.

Senator HARKIN. Do we have a copy of that? Would you give a copy of that to me, please?

Ms. BROWN. Yes, sir, I will.

Senator HARKIN. Let me rephrase that: Would you supply for the record a copy of that to this subcommittee?

Ms. BROWN. I will.

Senator HARKIN. All right. Because I would like to take a look at that.

Ms. BROWN. All right.

Senator HARKIN. I am glad you brought that up.

I was reading through your testimony last night, Ms. DeParle, and I was—just a couple of things leaped out at me.

On page five of your written testimony, you said, "We also removed about \$300 million in debt, as much as 10 years old, with no potential for collection from our financial statements. Some of these debts exceed the statute of limitations for collection."

Is there any way—do you have a system to cross-check or to ensure that those that skipped out on those are not back in the system, any cross-check of names?

Ms. DEPARLE. Yes, sir, I believe we do. And as you know, one of the first things you and I talked about was developing a comprehensive plan for program integrity, which we have now.

One of the items in it is provider enrollment to require providers to go through a process of enrolling and re-enrolling every so often. And I believe that system, which is underway now would catch folks like that.

However, there are still some gaps. And I believe we have talked to your staff about some of those that you might be able to help us with legislatively. Sometimes, a provider can be in business under one name and go out of business—

Senator HARKIN. Change—

Ms. DEPARLE [continuing]. And then come back suddenly as somebody else. And without an effort—without an ability to require them to report social security numbers and tax I.D.'s and things like that, it can be difficult.

But we do have a basic system, and I am sure there can be improvements made to it.

Senator HARKIN. Well, it just seems to me a simple question, if they are—if a provider is trying to get into the Medicare system, I am sure that in the paperwork that they have to fill out—I mean, it is just a simple question, “Have you ever done business with Medicare before under any other names, and please list those,” or “Have you ever been associated with any concern under other names?” And if they falsely attest to that, then that—that is fraud.

But it just seems to me if you have written that off, that there ought to be some way of checking to make sure that they are not back in the system today if they have skipped out on it.

I mean, I just have gone through a thing with student loan programs; and if we can do that with student loans, we ought to be able to do it here.

Ms. DEPARLE. I agree. In fact, they have called me about some of the things we are doing, so we are going to work together with them.

Senator HARKIN. What, the student loan program?

Ms. DEPARLE. Yes, sir.

Senator HARKIN. Oh, OK.

Ms. DEPARLE. There could be some analogies as you point out in the way we do business. The question that you mention, by the way, is on the application form for providers.

Senator HARKIN. Oh, it is?

Ms. DEPARLE. Yes.

Senator HARKIN. “Have you ever done business in another name,” or something like that?

Ms. DEPARLE. Yes, sir.

Senator HARKIN. OK.

Oh, yes, again, on page six, “While the national error rate has helped us focus our efforts on preventing improper payments, we need stronger tools to uncover the real problem areas. The key to this effort is our proposal to develop contractor specific error rates.”

Could you just briefly explain to me what that means? I do not—

Ms. DEPARLE. Yes. As the Inspector General noted, what we have is a national error rate, so it tells you what is happening across the entire country, with respect to documentation for physicians or durable medical equipment suppliers.

We need to be able to drill down and find out what the real problem is. Is that just a phenomenon that is occurring in a few areas of the country, or is it really all over the place?

And the kind of error rate that we have had, while it has been very good in helping us to focus our efforts on the biggest problems, it does not help us drill down as much as we need to.

I need to know whether we have a problem in Iowa or whether there is no problem in Iowa, and the fact is we need to be focusing the funds that you get us on the Southwest or whatever.

So we have now developed a program to do a contractor specific error rate; so these contractors who process the Medicare claims, we will be able to see how they are doing in paying claims correctly.

That will enable us to come up with corrective action plans. It will enable us to focus, if we need to, on providers in a specific area.

Senator HARKIN. Oh, OK.

Ms. DEPARLE. The Inspector General and I are working on a system to take that information and do a report card for the contractors. And that, in my view, is a way to more effectively manage these contractors.

And if I can just put in a plug, I think you know that this is the 8th year that the President has sent up to the Congress contractor reform legislation to change the way that that system is run.

I believe you have been supportive of that in the past, and I hope we can work with you again on it. I would really like to get that done. I think it is in the Government's best interest.

Senator HARKIN. I hope we can, too.

When you are talking about developing this. I mean, is this going to be something that you will have this year, or—

Ms. DEPARLE. Yes, sir.

Senator HARKIN. This year.

Ms. DEPARLE. We are starting it this year. We pilot tested it last year. And we are starting it with the durable medical equipment suppliers this year. So with all of those carriers, we will be doing this contractor specific error rate. And since, as you noted, that is a big part of our problem, I think that is an effective way to start out.

Senator HARKIN. So later this year, or this time next year, we will have some—

Ms. DEPARLE. Yes, sir, I believe we will.

Senator HARKIN. OK. Well, we have talked about the report cards, failure to improve, risk losing their Medicare business.

Well, again, you are talking about the report cards. I am going through your testimony again here, "Contractors who have performed poorly and failed to improve risk losing their Medicare business."

Will they know what they will have to do or they will lose it?

Ms. DEPARLE. Yes, sir, they will.

Senator HARKIN. They will have a heads up on that.

Ms. DEPARLE. We are going to amend their contracts this year to require them—when we identify financial management problems or internal control problems—by we, I mean, we, our independent auditors that are there and the Inspector General—they will have to do a corrective action plan and fix the problem. And if they do not, they will risk losing it.

But as you know, right now, under law, we are limited to a certain group of contractors to perform this work. And what I would like is to broaden that group.

Senator HARKIN. Yes. That is—

STAFF. That is in the bill.

Senator HARKIN. That is in the bill, too. But I just want to ask you about that. And, again, just making the point here, “We continue to seek contracting reform legislation to allow Medicare to use all firms capable of processing claims and protecting program integrity. Existing law requires Medicare to use only health insurance companies to process claims, and allows some providers to choose their claims processor. This has hampered our program integrity efforts.” So that is what you are getting at, is it not?

Ms. DEPARLE. Yes, sir. That is the contractor reform legislation that the President has sent up.

Senator HARKIN. Right. All right. “The I.G. and the GAO both have agreed we need to create an open marketplace in this—in this system.”

Ms. DEPARLE. Yes.

Senator HARKIN. Lastly, Ms. DeParle, where are we on competitive bidding?

Ms. DEPARLE. Well, I wondered—you held up a syringe this time, but I remember a hearing where you held up an oxygen tank.

Senator HARKIN. Oh, yes.

Ms. DEPARLE. I do want to tell you about that, because I am very excited about it. As you know we had an experiment, a demonstration, under the law that you helped us get to do competitive bidding for durable medical equipment in Polk County, FL.

Senator HARKIN. Yes.

Ms. DEPARLE. You were right that we should be doing it nationwide. So far the results of that demonstration have shown we are saving on an average of 17 percent.

And by the way, that is not just savings to Medicare. That is savings to the beneficiary as well because, as you know, they pay 20 percent of the cost of durable medical equipment. We did this, based not just on price. We had the suppliers bid based on price and quality.

Senator HARKIN. So you set up a quality standard?

Ms. DEPARLE. Yes, sir. And we have had an ombudsperson down there who has been dealing with the beneficiaries. The average savings are around 17 percent. On oxygen, we are saving 16 percent; on hospital beds, around 30 percent. So I believe it has been very successful.

And, in fact, today we are announcing another demonstration. As, you know, the law allowed us to do, I think, up to five. We are

announcing a second one in San Antonio, TX, on durable medical equipment. So we are trying to move forward there.

But as you know right now under the law, we have to pay based on a fee schedule for durable medical equipment, and the fee schedule information is very outdated. We are not getting the best prices for Medicare. So this kind of thing needs to be done nationwide and we appreciate your support in that.

Senator HARKIN. OK. Peter just—Mr. Reneke just told me that for oxygen that—you said it was 15 or 16 percent?

Ms. DEPARLE. In Polk County, yes, sir.

Senator HARKIN. That is over and above the 30 percent that we already made in the law.

Ms. DEPARLE. Yes. I should have made that point. You are right.

Senator HARKIN. Well, I guess I was only saying that because I remember when we first started having hearings that they could not make any cuts. So they then agreed on 30 percent. And 15 percent is over and above even that. That is 45 percent.

Ms. DEPARLE. That is right.

Senator HARKIN. Yes.

Ms. DEPARLE. And you asked us to look at it, and the GAO looked at it and so did the I.G.

Senator HARKIN. And obviously if there is competitive bidding, they can still make money doing it that way.

Ms. DEPARLE. Right. And the important thing is that we were all concerned about access, but we have not found any problems with access to oxygen services.

Senator HARKIN. I see. I said that was going to be our last question to you, but there was one other one that I just want to cover. And that is the inherent reasonableness clause and where we are on that.

I know there was something put in the legislation last year that stopped you from going ahead for a few months, but I think that is soon, is it not?

Ms. DEPARLE. It is soon, and, in fact, we had an exit conference Monday with Ms. Aronovitz and her colleagues at the GAO. What we are waiting for under the BBRA is for the GAO to give us its analysis of what the durable medical equipment suppliers carriers did in carrying out the inherent reasonableness provision of the Balanced Budget Act, and whether that was reasonable, the way they did it or not, to make those reductions. And once we hear from them, we will begin to move forward again.

Senator HARKIN. Again, for GAO, Ms. Aronovitz, do you believe that additional resources for program integrity activities are warranted? I just want to make that, for the record.

Ms. ARONOVITZ. Yes, absolutely. In terms of the budget that HCFA works within, it really is a shoestring. We think it is very important for HCFA to have additional funding, but it should be focused specifically with strategic plans and a detailed understanding of how to proceed. There have been indications that, when this does not happen, the money does not get used wisely.

I would like to back up a bit, if I could, and address a question that Chairman Specter had earlier about the concern of HMO disputes where people are uncertain about whether a service should be provided or if a service was denied by a plan.

We think there is even a more fundamental problem. We think that there is a possibility, and we actually have evidence to show that plans do not always do as good a job as they should in letting people know that they have the right to appeal some of the denials.

So even the denials that get appealed, you worry about due process; but a more fundamental problem is that the notices that go out to beneficiaries do not always say in simple language what their rights are.

And I know HCFA is doing a lot to try to fix that. But we are very concerned about the oversight that HCFA still has in assuring that plans are doing a good job in assuring that people understand what their rights are in Medicare + Choice plans. So that is something else we are going to be continuing to look at.

Senator HARKIN. Very good. Before I move on, I just want to, again, thank the GAO for all your good work. You have just been invaluable in getting us this information. And I just want to thank you, and thank the GAO for that.

Ms. ARONOVITZ. You are very welcome.

Senator HARKIN. Ms. Brown, this week, I released a new report you did, which found that on over 27,000 occasions in 1996 and 1997, hospitals readmitted patients on the same day they were discharged, often for the same DRG. In fact, a number of examples found this occurred four and five times in a row.

Clearly, in these cases, seniors are being used as pawns to rip-off Medicare. And not one of these cases was reported by our peer-review organizations. Can you enlighten us on this and what can be done to stop this type of abuse?

Ms. BROWN. Well, this is—the first step was identifying the problem. And I think that we now have met with HCFA on this issue, and they are taking steps to remedy that problem as well.

There is a lot of analysis that has to go on. We have looked at some cases where we have found that there were certainly reasons for readmission because they came back under a different DRG.

But there are numerous cases, some of them where people have come back six and seven times in a row and getting a new payment every time, where they are readmitted the same day, and it is the same DRG.

So it is certainly a problem area, and one that we are working to provide the analytical information that will allow HCFA to take action on this.

Did you have something to—

Mr. VENGRIN. Yes, Senator. I would like to embellish that answer a little bit more.

Senator HARKIN. Yes.

Mr. VENGRIN. And also going back to Senator Specter's remark about: How do you react to AMA's press release that this is too burdensome to really document this? We did this nationwide study and, in effect, found a 30 percent error rate.

Let me just give you a flavor for the types of errors we found. In 12 instances, the medical review said the beneficiary was prematurely discharged. In one case, they were readmitted, and the medical review said that the medical treatment was totally inadequate and caused the second readmission.

In eight additional cases, Senator, they rebilled for a readmission when, in fact, the beneficiary was still in the hospital and they did not know.

So in many of these cases, I would just be outraged at the type of response that we received from the medical community on this. I mean, this information needs to be clearly documented. And the hospital in this case did not even know that the patient was there.

Senator HARKIN. Well, I have got one here. One beneficiary was admitted to the hospital on July 14, 1997, discharged July 21, 1997, readmitted July 21, 1997, discharged August 1, 1997, readmitted August 1, 1997, discharged August 3, 1997, readmitted August 3, 1997, discharged August 13, 1997, readmitted August 13, 1997, discharged August 15, 1997, readmitted August 15, 1997, and finally discharged September 2, 1997.

In this case, the patient was readmitted to the hospital five times, and the hospital received six—six full DRG payments. And what was it this person from the AMA said? That this is irresponsible grandstanding—

Mr. VENGRIN. Correct.

Senator HARKIN [continuing]. That you are pointing this out?

Mr. VENGRIN. Correct.

Senator HARKIN. How irresponsible of you to point this out.

Mr. VENGRIN. Right.

Senator HARKIN. "It hassles, and overly aggressive billing audits are souring the physicians on Medicare Programs."

Well, you know, I had hoped that the—and I have said before, most of the doctors out there are not gaming the system.

Mr. VENGRIN. Correct.

Senator HARKIN. But doctors are human. And within every human, there is a sense of some greed and if an extra buck is to be made doing this or that, I mean—and that is why we had these audits set up to catch that.

It does no service to us and to the taxpayers and to the beneficiaries, for the AMA to take this kind of a head-in-the-sand kind of an approach. If anything is irresponsible, it is this letter from Nancy W. Dickey, AMA immediate past president. That is what is irresponsible, that statement.

Do we have anything else we want to cover? Do you have anything else you would like to add for the hearing at all, any of you.

Ms. DeParle.

Ms. DEPARLE. I would just add one thing, Senator. The last example that you had about the improper discharges, and cycling in and out—

Senator HARKIN. Readmissions, yes.

Ms. DEPARLE [continuing]. As your staff knows, we changed the focus a year ago of our peer review organizations, which you mentioned had not caught any of that for 1996 and 1997.

Senator HARKIN. Right, had not caught that, yes.

Ms. DEPARLE. And in their new contracts, one of the things they are required to do is something we are calling the payment error prevention program. And they are reviewing inpatient hospital claims for this kind of thing.

So I hope we will be able to have the same impact on that that we have had on the upcoding of claims for pneumonia that used to

always be coded at the top level and now all of a sudden, they are being coded more reasonably.

I hope it will have that kind of an impact, but you are right. It is irresponsible and inexcusable for that to occur.

Mr. VENGRIN. Senator, I would like to add one additional comment. If our statistics are correct, and I believe they are, 92 percent of the physician community did manage to get the regulations straight. So I think that speaks well of them. And I do not think they are quite that complicated.

Senator HARKIN. I appreciate that and I am glad you mentioned that for the record.

Well, thank you very much. And I want to work—continue to work with you especially on that contractor program and see what we can do about that.

You are going to give me the data on what you submitted to OMB, so I can take a look at it. And maybe we can correct that here this year in our appropriations process.

Ms. BROWN. Yes. I would be happy to, sir.

Senator HARKIN. I thank all of you.

Ms. DeParle, I thank you for your great leadership in this area. I know it has been tough and—but you have done a great job, and I appreciate it. Obviously, we have some other things we have got to do, but we got to keep on them.

Ms. Brown, thank you again for your great leadership.

And again to GAO and Mr. Vengrin, thank you very much for being here.

Ms. BROWN. Thank you.

Ms. ARONOVITZ. Thank you.

Ms. DEPARLE. Thank you.

Mr. VENGRIN. Thank you.

CONCLUSION OF HEARING

Senator HARKIN. Thank you all very much for being here, that concludes our hearing. The subcommittee will stand in recess subject to the call of the Chair.

[Whereupon, at 10:47 a.m., Thursday, March 9, the hearing was concluded, and the subcommittee was recessed, to reconvene subject to the call of the Chair.]

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